MANAGERIAL GUIDELINES TO SUPPORT PARENTS WITH THE HOSPITALISATION OF THEIR CHILD IN A PRIVATE PAEDIATRIC UNIT

by

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DISSERTATION

submitted in fulfilment of the requirement for the degree

MAGISTER CURATIONIS

in

PROFESSIONAL NURSING SCIENCE
(NURSING ADMINISTRATION)

in the

School of Nursing

at the

FACULTY OF HEALTH SCIENCES

of the

UNIVERSITY OF JOHANNESBURG

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NOVEMBER 2006

ACKNOWLEDGEMENTS

To God, through whom all things are possible.

To my parents, sisters and brother-in law… thanks for putting up with the books and papers all over. To Anton, thank you for the use of the printer and internet!

To Marco, and the always supportive Young-Petersen family, thank you for never complaining out loud about “The Masters”.

To Vasti (a.k.a my own therapist)… thank you my friend for always listening and letting me just express what I felt. I appreciate your unwavering support and belief in me.

To Prof K Jooste and Dr E Arries, thank you for your patience and repeated explanations. I believe the final product has been worth it.

ABSTRACT

The purpose of this research study was to describe managerial guidelines to support parents with the hospitalisation of their child in a private paediatric unit. The study explored and described:

- the nursing care experiences of parents regarding the hospitalisation of their child in a paediatric unit;
- managerial guidelines to support parents with their lived experiences of their child's hospitalisation in a private paediatric unit.

To achieve the purpose and the objectives of the research, an interpretive-phenomenological qualitative approach was used in the research design and method. Various questioning methods were employed during this study. Parents were invited to take part in unstructured individual interviews to ascertain parents' experiences of their child's hospitalisation. A narrative diary was used as the second method of questioning and parents were asked to narrate their lived experiences of their child's hospitalisation in a private paediatric unit. During the study the researcher kept field notes as she participated in the fieldwork. The data obtained was then incorporated into existing literature during the conceptualisation phase. The population and sampling for this study consisted of seven parents who took part in the interviews and 15 parents who completed the narrative diaries. Purposive sampling was used to achieve saturation of data. The model of Guba and Lincoln (1985) was used to ensure trustworthiness. Ethical considerations were maintained throughout the study and consent was obtained from the respondents. The recommendations of the research were that attention should be given to:

- empowering parents to participate in certain aspects of their child's care to the extent and intensity that they feel comfortable with, recognising parents' strengths and intrinsic characteristics and minimising feelings of parental guilt created by social roles;
- guiding nursing personnel to plan the discharge process effectively;
- including parents in the unit routine and managing resources whilst promoting cost containment;

- interpersonal relationships in the paediatric unit, with special emphasis on fostering a trusting and caring relationship between parents and nursing care professionals
- promoting the communication of information by using a communication style that ensures parents receive adequate information; and
- creating a safe, therapeutic environment for parents, where parents can be comfortable with adequate facilities and minimal external stimuli.

ABSTRAK

Die doel van hierdie navorsingstudie was om bestuursriglyne te beskryf vir die ondersteuning van ouers tydens die hospitalisering van hul kind in ‘n privaat pediatriese eenheid. Die studie het die volgende ondersoek en beskryf:

- die verpleegsorgervarings van ouers rakende die hospitalisering van hul kind in ‘n pediatriese eenheid;
- bestuursriglyne om ouers te ondersteun met hul deurleefde ervarings van hul kind se hospitalisering in ‘n privaat pediatriese eenheid.

Ten einde die doel en doelstellings van die navorsing te behaal, is ‘n interpretiewe-fenomenologiese kwalitatiewe benadering in die navorsingsontwerp en -metode gebruik. Verskeie ondervragingsmetodes is tydens hierdie studie gebruik. Ouers is genooi om deel te neem in ongestruktureerde individuele onderhoude om ouers se ervarings van hul kind se hospitalisering vas te stel. ‘n Narratiewe dagboek is as die tweede metode van ondervraging gebruik, en ouers is versoek om hul deurleefde ervarings van hul kind se hospitalisering in ‘n privaat pediatriese eenheid neer te skryf. Tydens die studie het die navorser veldaantekeninge gemaak terwyl sy by die veldwerk betrokke was. Die data wat verkry is, is tydens die konseptualiseringsfase in bestaande literatuur geïnkorporeer. Die populasie en steekproeftrekking vir hierdie studie het bestaan uit sewe ouers wat aan die onderhoude deelgeneem het en 15 ouers wat die narratiewe dagboeke voltooi het. Doelgerigte steekproeftrekking is gebruik om versadiging van data te verkry. Guba en Lincoln (1985) se model is gebruik om betroubaarheid te verseker. Etiese oorwegings is deurgaans gehandhaaf en toestemming is van die respondente verkry.

Die aanbevelings van die navorsing is dat aandag aan die volgende geskenk moet word:

- bemagtiging van ouers om aan sekere aspekte van hul kind se versorging deel te neem tot die mate en intensiteit waarmee hulle gemaklik voel; erkenning van ouers se sterk punte en intrinsieke kenmerke; en minimalisering van ouers se skuldgevoelens wat deur sosiale rolle veroorsaak word;
- leiding aan verpleegpersoneel om die ontslagproses effektief te beplan;

- insluiting van ouers in die eenheidsroetine en bestuur van hulpbronne terwyl kostebekamping bevorder word;
- interpersoonlike verhoudings in die pediatriese eenheid, met spesiale klem op die kweek van ‘n vertrouens- en versorgingsverhouding tussen ouers en professionele verpleegsorgpersoneel;
- bevordering van die kommunikering van inligting deur ‘n kommunikasiestyl te gebruik wat verseker dat ouers voldoende inligting ontvang; en
- die skep van ‘n veilige, terapeutiese omgewing vir ouers waar ouers gemaklik kan wees, met voldoende geriewe en minimum eksterne stimuli.

TABLE OF CONTENTS

TABLES

CHAPTER 1

Overview of the study

1.1 BACKGROUND AND RATIONALE

A change in the health of a child is regarded as a major stressor that requires social readjustment by parents and family members (Kaplan & Sadock, 1998:799). Any illness, no matter how minor in the eyes of trained nursing care professionals, is perceived as a crisis by parents – an event that upsets their everyday living and generates anxiety (Kibel & Wagstaff, 2001:544; Kozier, Erb, Blais & Wilkinson, 1998:195). The stress is further increased when the child is admitted to a paediatric unit in a hospital. Not only do the members of the family find themselves in a strange environment with strange sights and sounds and different technology, but very often limitations are placed on them by the hospital culture that they find themselves in. Visiting hours may be restricted, different clothes may be required, and the insertion of various devices (tubes, intravenous cannulas, catheters, monitors, etc) may impose limitations on the child's, as well as the family's movements within the paediatric unit. All of these circumstances can be very upsetting for the child being admitted. However, the child is not an isolated individual, and therefore the hospitalisation process of a child could be a stressful occurrence for the parents.

During the time leading up to a child's hospitalisation, as well as during the hospitalisation process itself, parents may experience a myriad of emotions, ranging from helplessness to agitation and guilt. Parents feel not only helpless, but also fearful of their child's illness. Some may feel guilty for not taking their child to the doctor earlier, because they believed "its nothing" or a passing phase. Then when the child requires admission, the parents may feel guilty and blame themselves for not being "better" parents. Should any complications occur, the parents now fear that they possibly caused these complications through their irresponsibility or reckless behaviour (Barber & Skaggs, 1998:143).

Parents naturally wish that they could spare their children from suffering. McCollum (1975:5) notes that parents expect it from themselves to keep their children safe, and therefore experience feelings of guilt, verbalised and manifested in many ways, for example "Is it my fault? Could I have prevented it if I'd cared for my child in a different way, or if I'd been a different person"?

A child's hospitalisation is particularly difficult, and parents who are already sad and worried about their child's condition, are likely to also feel frightened and agitated when hospitalisation is needed (McCollum, 1975:55). Despite the regular occurrence of children being hospitalised for varying degrees of illness and surgery, there is no consensus regarding how parents should be supported by nurses during the possible stressful period of hospitalisation of their child.

During a child's hospitalisation, parents have a unique perspective from which to report their experiences of their child's hospitalisation to the paediatric nursing unit manager. From the researcher's unstructured observations of parents within the paediatric unit, the researcher expected this perspective to be one of caring for, providing for and making decisions in the best interest of their child. Parents ultimately know what their child's specific needs are and how they can be met.

A previous study by Stratton, (2004:10) found that parents could experience their child's hospitalisation in a paediatric unit in terms of four interconnecting, circular processes;
(1) *facing boundaries* which includes parents feeling helpless and parents questioning the skills of personnel, as well as the way in which certain procedures are carried out;
(2) *attempting to understand,* which incorporates parents being informed or lack of information and simplifying communication;
(3) *coping with uncertainty,* highlighted by dealing with fear that parents have as well as the parents' need to create a comfort zone. Parents expressed the desire for caregivers to recognise and comfort the child, as well as the parents. A third aspect of coping with uncertainty was parents' attempts to try and protect their child;

(4) *seeking assurance* from caregivers, which includes the characteristics that parents would have liked emulated in their caregivers, namely expressing concern, being supportive and attending to detail.

Stratton's study concluded that the experiences shared by the parents conveyed new meaning to the interactional nature of the parents-caregiver relationship. In particular, parents make use of the parent-caregiver relationship to help them cope with their child's condition and this, in turn, influences the parents' sense that their child's, and their own needs, are being met (Stratton, 2004:10).

The reliance of parents on the parent-caregiver relationship highlights the need for a supportive relationship between parents and nursing personnel within the paediatric unit. Various emotions are at play during a child hospitalisation, and parents feel relatively disempowered when dealing with illness in their children. They struggle to make sense of their child's illness. Their experiences of seeking advice from professionals could leave them feeling uncertain and uninformed. The disparity between the parents' beliefs and expectations about illness and treatment, and professionals' behaviour further frustrate parents' attempts to understand their child's illness (Kai, 1996:25). These factors could act as sources of dissatisfaction and sometimes disharmony in the relationship between parent and professionals.

Parents tend to be troubled by their negative feelings. These troubling feelings, together with feelings of anger, grief, bitterness and helplessness could be vented on unsuspecting, well-meaning nursing personnel. Parents may find themselves feeling critical of almost everything done by the professional personnel. Without intending to, parents can become blinded to any actions that reveal competence, concern and compassion by nurses. The sense of angry protest that parents could experience seeks a target; in the hospital setting, that target is often the nursing personnel.

Parents are also under the impression that no one could know their child better than they do, and as such they want to do everything for their child, in the manner that they feel is

best for their child. When the child is admitted to a paediatric unit, this care is often taken over by the nursing personnel, especially during the initial admission period, where personnel members examine the child, do blood tests, take x-rays, make measurements made, engage in hushed conversations, or exchange worried glances. Parents may feel that they are pushed aside during this time (McCollum, 1975:6).

In his study regarding parental participation and involvement in the care of the hospitalised child, Philip Darbyshire (in Benner, 1994:185-209) notes that, since the publication of the Platt Report in the United Kingdom, there have been various attempts to humanise paediatric units by offering open visiting hours and living-in facilities for parents, and by encouraging parents to take a more active part in their child's care while they are in hospital.

Through his study of parents' as well as the nursing personnel's perception of parental participation Darbyshire (in Benner, 1994:185-209) concluded that the term parental participation seemed to have a meaning for nurses and parents that implied an arrangement whereby one party, the parents, would be allowed by the other party, the nurses, to help with their child's care. However, the impression gained seemed to imply that the nurses perceived the parents as being able to only do the work of an unqualified member of the personnel, namely the parental work. Darbyshire argues that the concept of parental participation was more similar to "parents who stayed for a long time and helped out the personnel", rather than an involvement whereby parents felt that they had retained an acceptable control over both their own and their child's lives.

McCollum (1975:56) advocates that parents should be encouraged to help care for their children, especially by feeding, bathing, changing, dressing and playing with them. Parents however, may feel emotionally torn about visiting. They wish to be with their child to comfort and reassure them, and to observe their condition and progress directly, but on the other hand, visiting or living in may be difficult and upsetting. Parents' discomfort may be intensified because they lack the familiar, organising influence of their usual routine of daily work.

In order to accommodate the parents' need to continue performing their parenting tasks, family-centred care has been introduced to nursing units over a period of time, and in varying degrees. One aspect important to this study is the concept of parent participation. A narrow definition of parent participation in hospitalisation is "to include performance of routine physical care and extended visiting" (Knafl, Cavallari, & Dixon, 1988:98). An extreme form of parent participation is the establishment of care-by-parent units, wherein nursing personnel are only minimally involved and parents provide all physical and emotional care for their child (Knafl et al., 1988:99).

Acutely ill children require special equipment and special nursing care. However, as the child's condition improves, so the scope of care that parents can deliver increases, so that by the time the child is well enough, the parents are able to perform all parenting tasks in totality (Passero, 1988: 3-4).

Darbyshire (in Benner, 1994:188) differentiated between the terms involvement and participation. Participation refers to the more functional involvement of parents with their child's care. Involvement has a more holistic connotation, implying a deeper sense of being an integral and essential part of their child's hospital experience.

When a child is hospitalised, parents' priorities, roles and values change. Parents are characterised by placing high levels of trust in professionals, relinquishing control over decision-making to physicians and nurses, and receiving information rather than seeking information and care (Knafl et al., 1988:109). Also, parents' role in participating in their child's care is not always clarified. Darbyshire noted in his study that parents were often confused and uncertain as to exactly what they were allowed and expected to do during their child's hospitalisation (Benner, 1994:190).

Parental involvement in the care of hospitalised children has been encouraged by the governments of the United Kingdom, Brazil and America (de Lima, Rocha, Schochi & Callery, 2001:599), with many reports being issued to the effect of including parents in the

care of their children during a hospitalisation episode. The role of the family in a child's illness is slowly being recognised in South Africa (Kibel & Wagstaff, 2001:544), but this is by individual authors and the South African government per se has not issued any formal reports on parental participation in the hospitalisation process.

The discrepancy between the nursing practice and nursing theory emphasises the need for a study to describe and explore parents' reality. It can be deduced that if there are few or no studies about parents' lived experiences of their child's hospitalisation, there were no managerial actions or strategies in place to facilitate the findings of such a study. Indeed, in South Africa there are no known strategies in place to facilitate parents' experiences within a paediatric unit.

1.2 RESEARCH PROBLEM

As mentioned in the background and rationale (point 1.1) the lack of role clarification and the change in parents' priorities and values during the hospitalisation of their child are all sources of conflict. Ambiguity and uncertainty as to the boundaries of acceptable behaviour of parents in the paediatric unit can cause conflict. The disruption of the balance of power between a nurse and parent may also be an aggravator of conflict. Conflict exists in a relationship when parties believe that their aspirations cannot be achieved simultaneously, or perceive a divergence in the values and needs (Anstey, 1997:6, 13). This conflict often manifests itself in the responses obtained in patient opinion surveys which parents are requested to complete.

Patient opinion surveys completed by parents in a paediatric unit within a private hospital (Vereeniging Medi-Clinic unpublished: 2004) indicate that parents are experiencing their child's hospitalisation negatively. Comments made include that "personnel are not friendly", "too few personnel for the number of patients", "day personnel more competent than night – more helpful", and "medication not given as prescribed". It is seldom that nursing services obtain satisfying results, like "good" and "excellent", on the Likert scale used. No follow-ups have been done on these comments, and no investigations have been

instigated by management, to document parents' lived experiences and how these can be effectively managed within the paediatric unit. Dissatisfaction of next of kin with patient care is one of the five categories that Booyens (ed) (1998:593) recognises as a high-risk area. It is also noted that nursing personnel are involved in this area. It must be mentioned that a survey or Likert type instrument does not capture the deeper meaning of an experience, and this shortcoming in data collection once again highlights the need to conduct research in such a manner as to capture the deeper meaning of parents' experiences of their child's hospitalisation in a private paediatric unit. One such method of capturing the deeper meaning of parents' experiences is the use of unstructured interviews. The benefits hereof is described later in chapter one.

Dissatisfied parents are the ones most likely to pursue further action. Thus, it forms part of risk management to identify incidents that may lead to further action, educate parents and their families about the care being given to the child, and handle parents' complaints (Marriner-Tomey, 1996:457). The unit manager's role within the unit is to manage the unit to the benefit of stakeholders and the patients, as well as their parents. A unit manager is responsible for giving guidance and assistance to all nursing personnel in this regard. By effectively managing the conflict that arises from parents' dissatisfaction, the unit manager is able to effectively manage the unit to the benefit of all parties.

To understand lived experience is to "uncover meanings in everyday practice in such a way that they are not destroyed, distorted, decontextualised, trivialised or sentimentalised" (Benner, 1985:6). One needs to understand as much as possible about the lived experiences of parents that affect the nurse-child-parent interaction. Lived experiences are embedded with meaning. The meaning that is embedded within the lived experience of parents regarding the hospitalisation of their child will shape their perceptions of the hospitalisation process. It is through as comprehensive an understanding as possible that unit management and nursing personnel can effectively care for, support and facilitate the parents with whom they work (Fitzpatrick & Montgomery, 1999:65). It is through a comprehensive understanding of parents' lived experiences that risk management can be effectively conducted, to benefit all shareholders.

1.3 RESEARCH QUESTIONS

The study raises the following questions:

- What are the lived nursing care experiences of parents regarding the hospitalisation of their child in the private paediatric unit?
- How can parents lived nursing care experience of their child's hospitalisation in a private paediatric unit be managed in a supportive manner?

1.4 PURPOSE OF THE STUDY

The purpose of this study was to describe managerial guidelines to support parents with the hospitalisation of their child in a private paediatric unit.

1.5 RESEARCH OBJECTIVES

The objectives of this study are to:

- explore and describe the nursing care experiences of parents regarding hospitalisation of their child in a paediatric unit;
- describe managerial guidelines to support parents with their lived experiences of their child's hospitalisation in a private paediatric unit.

1.6 PARADIGMATIC ASSUMPTIONS

Benner (1994:71) describes the basic assumptions of interpretive-phenomenology as follows:

1. Human beings are social, dialogical beings, thus making use of an interview as a method of data collection will allow for this.
2. Understanding is always before us in the shared background practices; it is in the human community of societies and cultures, in the language, in our skills and activities, and in our intersubjective and common meanings.

3. Interpretation presupposes a shared understanding and therefore has a threefold fore-structure of understanding.
    a. A fore-having: we come into a situation with a practical familiarity, that is, with background practices from our world that make interpretation possible;
    b. A fore-sight: because of our background we have a point of view from which we make an interpretation;
    c. A fore-conception: because of our background we have some expectations of what we might anticipate in an interpretation.

    This is very important for the study as it emphasises the need for the researcher to make use of "bracketing". Bracketing involves "putting aside" our preconceived ideas and perceptions and allowing the researcher to focus on the respondent's experience. Bracketing can be described as a sincere attempt not to allow one's beliefs and assumptions to shape the data collection process, and a persistent effort not to impose one's own understandings and constructions on the data. Instead the data should be allowed to emerge in its own form (Crotty, 1996:20).
4. Interpretation involves the interpreter and interpreted in a dialogical relationship, thus again emphasising the importance of dialogue in the form of an interview.

1.7 DEFINITION OF KEY CONCEPTS

1.7.1 Child as defined by the Child Care Act (No 74 of 1983) is "any person under the age of 18 years". In this study the terms paediatric and child were used interchangeably.
For the purposes if this study a child is a person aged between 6 weeks to 12 years (of either sex), suffering from no major physical or mental impairments other than the one for which hospitalisation was required, and who is expected to make a total recovery following treatment. The patients included both medical and surgical patients, and only parents of children who were admitted in the unit (i.e. this excluded all out-patients) were used for data collection purposes.

1.7.2 Paediatric unit is a unit within a hospital accredited for the treatment and care of ill children. In order to allow for the researcher's convenience, the study was conducted within a private hospital. As the study focused on typical paediatric hospitalisations, the paediatric unit used for data collection was a typical private hospital paediatric unit, thus excluding ones which specialise in certain conditions or purport to have experimental or especially innovative paediatric programmes. The study was conducted in the Vaal Triangle region of Gauteng, South Africa.

1.7.3 Parent (including adoptive parent) is legally defined as a mother or father. Parenting is defined by the Oxford Dictionary (Thompson (ed) 1996:674) as the "bringing up of children". Thus, for the purposes of this study, a parent is defined as a mother or father (including step-parents as well as single parents) who are raising the child. For data collection purposes the mothers and/or fathers (including step-parents and single parents) who were involved with the paediatric unit routine were approached.

1.7.4 Lived experience is defined by Benner (1994: xi) as being engaged in practices as a being who acts in and on the world. Lived experience is understood to be the ways in which people encounter situations in relation to their interests, purposes, personal concerns, and background understanding (Benner, 1994:186). Lived nursing care experience thus implies someone who is engaged in the nursing care/hospitalisation practice. Parents who engaged in their child's hospitalisation were therefore used for data collection purposes.

1.7.5 Manage is defined by the Oxford Dictionary (Thompson (ed) 1996:538) as "organise, regulate or be in charge of". In a nursing context, **management** is described by Yura et al., (in Mackenzie, 1998:178) as the use of delegated authority within a formal organisation to organise, direct and control.

1.7.6 Guidelines refer to standards or principles by which to determine and direct policies or actions (Collins Pocket Dictionary, 1983:377; Thompson (ed), 1996:332). **Managerial guidelines** therefore are actions that are implemented from management downwards, during the phases of planning, organisation, delegation and controlling. In this study

management was defined as the planning, organising, guiding and evaluating of parents' lived nursing care experiences which had to be effectively addressed in the paediatric unit routine.

1.7.7 Hospitalisation as defined by the Oxford dictionary (Thompson (ed) 1996:424) is to "send or admit to hospital". In this study the term hospitalisation refers to all the management processes (nursing activities and functions) that occur within the paediatric unit once the child is physically placed in a bed within the unit. One of the processes that occur within the hospitalisation process is that of the unit routine. Muller's (2002:127) definition of unit routine was applied in this study: "Routine refers to the standardisation of the daily functions and activities in the nursing unit to facilitate quality nursing care and optimal utilisation of personnel, time and other resources."

1.7.8 A **nursing care personnel** is a person who has completed the minimum requirements for education and training of a nurse, leading to registration or enrolment with the South African Nursing Council (South African Nursing Council, 1985). For purposes of this study, enrolled nurses as well as registered nurses will be regarded as nursing care personnel.

1.8 RESEARCH DESIGN AND METHOD

As the focus of this study was the interpretation of lived experiences, one had to use an appropriate qualitative research design and method to ensure that the data is obtained and analysed in such a manner as not to "lose" or misinterpret the essence of the experience. With this in mind, this study was conducted within an interpretive-phenomenological paradigm.

1.8.1 Research design

This was an *interpretive-phenomenological qualitative* study whereby the lived nursing care experiences of parents were *explored* and *described* within a *context*, within an

interpretive-phenomenological approach. An interpretive approach allows for a specific way to interpret the captured lived experience, whilst phenomenology allows for the capturing of the lived experience of the parents. These two approaches have a synergistic relationship.

1.8.2 Research method

The research method that was used in this study can be categorised into the questioning methods, as well as the conceptualisation that took place, and allowed for conceptualisation of the raw data into current available literature. A brief discussion of the questioning methods and conceptualisation will now follow.

Various questioning methods were used during this study. Firstly parents were invited to take part in an unstructured individual interview to ascertain parents' experiences of their child's hospitalisation. An unstructured interview allows the researcher to approach a subject in a broad sense, and then encourage respondents to elaborate on more specific dimensions as the interview progresses. As with all interviews, an unstructured interview allows the interviewer to access the deeper meaning of the respondent's response (Burns & Grove, 2001:422,814). In order to facilitate the exploration of deeper meaning the interviewer used open-ended questions.

A narrative journal was used as the second method of questioning and parents were asked to narrate their lived experiences of their child's hospitalisation in a private paediatric unit.

During the study the researcher kept field notes as she participated in the fieldwork in the private paediatric unit. The keeping of extensive field notes of observation during a qualitative research study is an acceptable form of data collection, and is perceived as being essential in order to capture the context of observations (Mouton, 2002:108).

The above thus summarises the three questioning methods that were used throughout this research study.

The criteria to be applied for literature used in the conceptualisation phase were presented in Chapter 2. As with all research studies, findings need to be incorporated into existing literature and so increase the base of knowledge. By reviewing all available, relevant literature, it is possible to interpret findings (Burns & Grove, 2001:107,111). The relevant sources were identified, making use of computerised databases, and this ensured that the most recent international and national findings from other research studies were available for comparison to and confirmation of the findings of this study.

The above-mentioned are aspects relevant to the questioning methods and criteria used for the conceptualisation phase. The criteria that were applied for the population and sampling will now be discussed below.

1.8.2.1 Population and sampling

Parents whose child was at that stage being hospitalised in a private paediatric unit were used for the data gathering phase of the research. The study was conducted in one of the private hospitals in the Vaal Triangle region of Gauteng, South Africa. Criterion-based purposeful sampling was conducted.

The criteria for selection of parents to take part in this research study regarding parents' experiences of their child's hospitalisation in a private paediatric unit are outlined in Chapter 2.

1.8.2.2 Data collection

In interpretive studies, the primary source of knowledge is everyday practical activity. Human experience becomes a text analogue that is studied and interpreted in order to discover the hidden or obscured deeper meaning of a phenomenon. Given that our everyday lived experience is often so taken for granted as to go unnoticed, it is frequently through the dissemination of the text analogue that the researcher achieves flashes of insight into the

lived world (Benner, 1994:59). Interviews, narrative studies, field notes and a conceptualisation of the data allowed for parents' experiences of their child's hospitalisation in a private paediatric unit to become a text analogue, which could then be interpreted.

An unstructured, individual *interview* was used as the primary data collection method. Interview questions, commencing with an opening question and followed by probing, explored parents' experiences and probed into their thoughts, feelings, concerns and worries during the hospitalisation of their child. Participants were respected in terms of ethical considerations.

As a secondary data collection method*, narrative diaries* were handed out on admission to parents whose child was expected to remain in the unit for at least three days, and who gave consent.

The *conceptualisation phase* was conducted in order to merge the findings of this research study into the already existing body of knowledge that was relevant to parents' experiences of their child's hospitalisation in a private paediatric unit. The merger of new knowledge and existing knowledge served as the conceptualisation of parents' experiences of their child's hospitalisation and gave the findings deeper, more meaningful significance.

1.8.3 Data analysis

Data analysis is the organising of raw data and displaying it in a fashion that will provide answers to the proposed research questions (Brink, 2001:178). Data analysis entails categorising, ordering and summarising the data, and then describing the data in meaningful terms. Transcribed interviews, narrative diaries and field notes were treated as text analogues for interpretive analysis.

Making use of Tesch's method of open-coding, as described in Cresswell (1994:155), the transcribed interviews, narrative diaries and the researcher's field notes during the

individual interview were analysed. The inclusion of the researcher's field notes was important for the enrichment of the data.

An intensive conceptualisation was conducted in order to explore, describe and confirm the findings of the research study, as well as to facilitate the designing of managerial guidelines to effectively support parents' lived experiences of their child's hospitalisation in a private paediatric unit.

1.8.4 Trustworthiness

Measures to ensure trustworthiness were applied. Guba's (Guba & Lincoln, 1985:290-327) strategies of credibility, transferability, dependability and confirmability were implemented.

Table 1.1 Summary of strategies which were used to establish trustworthiness

Strategy	Criteria
Credibility	a) Prolonged field engagement b) Reflexivity c) Triangulation (observation and field notes) d) Interview technique e) Peer group discussion
Transferability	a) Dense description b) Nominated sample
Dependability	a) Dense description of research method b) Co-coding of data (independent coder)
Neutrality	a) Triangulation b) Reflexivity

1.9 ETHICAL STANDARDS OF THE STUDY

Ethical measures were adhered to during the research regarding this sensitive issue of parents' experience of their child's hospitalisation (Burns & Grove, 2001:191-210). The research also adhered strictly to the ethical considerations according to the standards of the University of Johannesburg.

The researcher obtained ethical approval for the study from the Rand Afrikaans University (now University of Johannesburg Ethical Committee) prior to commencing the study (see Annexure 1). Parents also signed a letter of consent (see Annexure 2) before being interviewed or completing the narrative diary. The following explains how the ethical standards of the institution were applied to the study.

The right to privacy, confidentiality and anonymity

- The researcher communicated the data in such a way that no individual's personal identity could be associated with it. Only the researcher was aware of the origin of the data. Neither the narrative diary nor the transcriptions contained the parents' names or any form of identification.
- Parents were requested to hand the narrative diaries back to the researcher on the day of discharge. The diaries could not be identified by the parents' names and participation was voluntary. The diaries were not requested prior to discharge to ensure that no victimisation of the parents, based on what was disclosed in the narrative diary, could take place.
- Should it occur that the anonymity of parents be endangered at any time, the research records (i.e. transcriptions and narrative diaries) would be destroyed immediately.
- The researcher respected the individual parent's right to privacy, confidentiality and anonymity by not allowing any form of identification on the transcriptions or narrative diaries. The use of individual, rather than focus group interviews, also promoted confidentiality and anonymity.

- In order to prevent exposing and embarrassing the participating parent, the researcher ensured the individual's privacy, by conducting the interview in a sound-proof, private cubicle, with only the researcher and parent present. In order to minimise any possibility of the parents feeling embarrassed at any time during the interview, the researcher had decided to make use of individual, unstructured interviews, rather than focus group interviews where parents may feel embarrassed in front of other parents. A focus group interview would also have jeopardised parents' anonymity.

The right to equality, protection, justice and truthfulness

- The researcher planned and executed the research in such a way that it was to the parents' benefit, and that there were no harmful, physical or psychological experiences for the parent or child. Interviews were held at a time convenient for the parents, during their child's admission. The child was cared for by nursing personnel for the duration of the interview.

The right to freedom of choice, withdrawal and access to information

- Parents were required to give written informed consent before the research interview/narrative diary was commenced.
- Participants did not feel pressurised in any way to participate in the research.
- Participants could withdraw at any time without fear of discrimination or exposure and embarrassment. There was also no impact on the nursing care that their child received.
- The researcher clarified all information, and these results will be available to parents.

Rights of the community and the research community

- The researcher maintained the highest standards of research planning, implementing and reporting.
- The researcher was tied to honest, unbiased and neutral research.
- All research findings were made available.
- The restraints of the study were made known.
- No unethical manipulation of the research data took place.
- The researcher made use of acceptable, scientific methods and procedures throughout the research process.
- All conclusions and statements were justified by reputable sources.
- No plagiarism was allowed.
- Contributions from other researchers were acknowledged.

1.10 OUTLINE OF THE STUDY

Chapter 1	:	Overview of the study
Chapter 2	:	Research design and methods
Chapter 3	:	Nursing care experiences of parents regarding the hospitalisation of their child
Chapter 4	:	Conceptualisation
Chapter 5	:	Guidelines, limitations and recommendations

1.11 CONCLUSION

In this chapter, the problem to be researched, as well as the motivation for this research study have been discussed. The research design and methods have been broadly overviewed. In chapter 2, more emphasis was placed on, and an explanation given of the research design and methods.

CHAPTER 2

Research design and methods

2.1 INTRODUCTION

In Chapter 1 the rationale and purpose of this research study were described. This chapter is concerned with the methodology of the study. The purpose of this chapter is to describe and justify the research design and methods used for this study. According to Burns and Grove (2001:745) the design "directs the researcher in planning and implementing the study in a way that is most likely to achieve the intended goal. It is the blueprint for the study". The methods used with regards to population and sampling, data collection and data analysis were discussed, as well as methods to ensure trustworthiness.

2.2 OBJECTIVES OF THE RESEARCH

The objectives of this study were to explore and describe:

- the nursing care experiences of parents regarding the hospitalisation of their child in a paediatric unit;
- managerial guidelines to support parents with their lived experiences of their child's hospitalisation in a paediatric unit.

2.3 RESEARCH DESIGN

This was an interpretive-phenomenological qualitative study whereby the lived experiences of parents were explored and described within a context, within an interpretive-phenomenological approach. An interpretive approach allows for a specific way of interpreting the captured lived experience, whilst phenomenology allows for the capturing of the lived experience of the parents. These two approaches have a synergistic relationship. Interpretive and phenomenological analyses, which focus on the meaning structure of lived experience directly and not via causes, are helpful tools in making sense of the being-in-the-world of illness (Svenaeus, 2000:126).

2.3.1 Interpretive

Palmer (1969:13) traced the roots of interpretive analysis and reports that the various forms of the word suggest the process of bringing a thing or situation from unintelligibility to understanding. In this research study the underlying meaning of parents' lived experiences of their child's hospitalisation in a private paediatric unit was explored in order to gain an understanding.

This study was suitable for an interpretive approach in that it seeked to understand the lived experiences and everyday meanings of the experiences, thoughts and ideas of the parents who had experienced their child's hospitalisation.

2.3.2 Phenomenology

In keeping with the interpretive approach which strives to explicate meaning from an experience, phenomenology represents another attempt at the explication of meaning, but the object of reflection here is the experience itself. Experience is looked upon as a structure of meaning, not as pure formless content. Thus, this study strived to explore and describe the meaning embedded in parents' lived nursing care experiences within a private paediatric unit setting.

Phenomenology has been described as the use of subjective and first-person experiences as a source of knowledge (Smith, 1999:359), i.e. parents experiencing their child's hospitalisation. Phenomenology is about exploring and developing insight into the world "as it is experienced" (Van Manen in Paton, Martin, McClunie-Trust, Weir; 2004:176). However, the reflection is "on-action" rather than "in-action", and descriptions of experiences are retrospective. This retrospective description was recorded in the narrative dairy, should the parents have chosen to complete it.

By engaging in the interpretive process, the researcher seeked to understand the world of concerns, habits and skills, presented by the participants' narratives and situated in actions. This understanding was then used to contract similarities and differences between other participants' narratives and situated actions. Understanding human

concerns, meanings, experiential learning and practical everyday skillful comportment is the goal of the interpretive process (Benner, 1994: xiv).

Drew (in Smith, 1999:359) notes that nursing research has made this research design popular as it "honours human experience". Phenomenological researchers hope to gain understanding of the essential truths of the lived experience. Phenomenological research is a human science that strives to "interpret and understand" rather than to "observe and explain" (Morse, 1991:56).

2.3.3 Qualitative

A qualitative design enabled the researcher to explore and describe the parents' experiences in an in-depth and holistic manner. The goal of qualitative research is to arrive at some general, overall appreciation of a phenomenon – thus highlighting interesting aspects and perhaps generating specific hypotheses. Put otherwise, qualitative research provides an initial description of a phenomenon – in this study the experiences of parents.

Qualitative research usually yields a lot of information. This research design can yield information about major themes and factors at play highlighting areas that might warrant more in-depth quantitative study.

Using this research design, the study therefore aimed to explore and describe the experiences of parents during the hospitalisation of their child.

2.3.4 Explorative

When a study is explorative (Talbot, 1994:90) it attempts to uncover relationships and dimensions of a phenomenon. It investigates the manner in which the phenomenon manifests itself to other related areas. This manifestation generates a new understanding of the phenomenon and thus has the potential to generate statements or hypotheses (Mouton & Marais, 1989:43).

This research study was concerned with exploring the experience of parents during the hospitalisation of their child. The researcher departed from a point of reference of not knowing. The design was exploratory and thus suitable for gaining insight into the experience of the parents in this context. The understanding of parents' lived nursing care experiences contributed to the formulation of managerial actions to be implemented to support parents during the hospitalisation of their child.

2.3.5 Descriptive

When a study is descriptive, it is similar to the explorative type of study, but more structured (Talbot, 1994:90). The main purpose was to examine relationships amongst variables.

In this study, the lived nursing care experiences of parents were explored and described.

2.3.6 Contextual

When a study is contextual it aims to focus on the specific set of properties that pertain to a phenomenon: that is the location of events and incidents pertaining to a phenomenon along a dimensional range. Straus and Corbin (1990:96) summarise context as the particular set of conditions within which the action/interactional strategies are taken. Talbot (1994:93) argues that context explains why certain attributes of a phenomenon appear when they do, and how they are interconnected. When an interpretive approach is going to be used, it is important to note that it relies heavily on the particular context of the situation, that is the timing, meanings and intention of the particular situation (Benner, 1984:40).

Context implies the conditions and situations of an event. It is important to note that the parents' experiences in this context are unique and that their experiences in another context may be completely different. In this research study the focus was on the lived experience of parents during their child's hospitalisation in the private paediatric unit.

This study was contextual in that it dealt with the experiences of parents whose children were hospitalised for three days or longer in a typical private paediatric unit.

2.4 RESEARCH METHOD

Qualitative questioning methods were used in this research study, including individual interviews, narrative diaries and field notes. Conceptualisation of the data into existing data was also undertaken. This ensured data saturation and triangulation.

An unstructured, individual interview was used to explore and describe parents' lived nursing care experiences during the hospitalisation of their child. This method is useful as an approach to human inquiry that emphasised the complexity of human experiences; the need to study the experiences holistically as it is lived (Polit & Hungler, 1997:651). It allows the individual free-flow of thought, feelings and emotions, which are charged with meaning.

Narratives were used to understand the meaning that parents attached to their child's hospitalisation in a private paediatric unit. The use of narratives allowed the researcher to gain more insight into parents' experiences (Burns & Grove, 2001:605-606).

2.4.1 Population and sampling

Parents whose child was being hospitalised in a paediatric unit in a private hospital situated in the Vaal Triangle were used for the data collection phase of the research. Purposeful sampling, based on specific criteria, was used to select parents to take part in this research study. Parents whose child was admitted in the paediatric unit during the months of April 2005 to June 2005 formed part of an accessible population, and thus they were used for data collection purposes.

Purposive sampling is the selection of a sampling group based on predetermined criteria. This criteria is chosen according to the extent to which the selection group can contribute to the research study. The goal of purposive sampling is to gain an understanding of phenomena and to get sufficient detail to provide information to design subsequent studies. Therefore non-probability, non-randomly selected samples are required (Brink, 2001:134).

Purposive sampling chooses subjects who are judged to be typical of the population in question, or who are particularly knowledgeable about the issue under study (Polit & Hungler, 1997:229). In this research study the subjects were understood to be typical of the parents in question – typical in so far that their child was hospitalised in a private paediatric unit for medical purposes.

In total, seven interviews were conducted with consenting parents and fifteen narrative diaries were completed and handed in on discharge day by parents. This enabled data saturation to be obtained.

Thoughtful planning was required for appropriate participant selection. The criteria for parents' selection were as follows:

- The parents should be able to communicate in English or Afrikaans;
- The parents should be biological parents (mother or father), adoptive parents, single parents or step-parents;
- The parents' child should be formally admitted in a paediatric unit within a private hospital;
- The hospitalised child should be aged between six weeks and 12 years of age;
- The child should be hospitalised in the paediatric unit for a minimum of three days (three days being the shortest duration of antimicrobial treatment);
- The parents should be visiting their child at least once a day in order for them to be able to actively participate in their child's care; and
- The parents should be willing to reflect freely on their lived nursing care experiences and convey it to the researcher (using the questioning method of their choice, i.e. interview and/or narrative diary).

2.4.2 Data collection methods

As described in chapter one a variety of data collection methods were used during this research study. Three forms of questioning methods, namely the unstructured interview,

narrative diaries and field notes, were used, together with a conceptualisation of the data into existing literature.

2.4.2.1 Unstructured interview

Unstructured, individual interviews were used to explore and describe parents' lived nursing care experiences during the hospitalisation of their child. This method is useful as an approach to human inquiry that emphasises the complexity of human experiences; the need to study the experiences holistically as it is lived (Polit & Hungler, 1997:651). It allows the individual free-flow of thought, feelings and emotions, which are charged with meaning.

Kvale (1983:171-175) describes some aspects of the qualitative research interview that are applicable to this study. These aspects emphasise the usefulness and applicability of this method of data collection for this study. Firstly the subject of the qualitative research interview is the *life world* of the respondents and their relation to it. The purpose was to describe and understand the central themes the respondents experienced. In this study, the hospitalisation of their child was the main theme in the life world of parents, and the interviews seeked to reflect this theme.

The researcher also aimed to describe and understand the *meaning* of the central themes in the life world of the parents. The most important task of interviewing was understanding what is being said.

In keeping with the objectives of this study, the researcher aspired to obtain as many nuanced descriptions from the different aspects of the respondents' life-worlds as possible. Making use of bracketing as described earlier, the interviewer strived to obtain uninterpreted *descriptions*. The parents described, as precisely as possible, what they had experienced and felt during their child's hospitalisation. *Specific* situations and action sequences in the life-world of each parent were described.

The interviewer also attempted to gather as rich and *presuppositionless* descriptions of the relevant themes of the respondents' life-worlds as possible. The use of bracketing and intuiting (Burns & Grove, 2001:80) was beneficial in ensuring that the researcher

remained bias-free. The interviewer was curious about and sensitive to what was said, and to that which was not said and critical of her own assumptions and beliefs during the interview. The interviewer remained *focused* on certain themes of the life world of the respondents.

The interview was neither strictly structured with standardised questions, nor entirely "non-directive" but was focused on certain themes: using an opening question (this research was directed by one open-ended question namely, "How did you experience your child's hospitalisation in the paediatric ward"), followed by probing when the responses of the parents were *ambiguous*. It was the task of the researcher to seek clarity as far as possible. On occasion during the interviews, parents *changed* their descriptions and beliefs and their understanding of their life worlds and lived healthcare experiences. This happened as they explored new meanings during the interview that had possibly never occurred to them before. This emphasised that the interview had been a *positive experience* and that participants had benefited from the study. This was an important ethical consideration, as the parent had to be protected from harm.

The interview is an *interaction* between two people. Morse (1991:61) argues that in a phenomenological interview the term "conversation" rather than "interview" is chosen to more fully describe the process used. As opposed to the word "interview" which implies one person (the interviewer) asking questions to another person, the word "conversation" implies a discussion and best captures the attitude of this interaction. Like an interview, the conversation has a central theme focus, but it is not one-sided.

The researcher facilitated the interview by creating an open, comfortable, non-threatening atmosphere. The researcher created a context where the respondents could speak freely and openly by utilising communication techniques such as clarification, paraphrasing and summarising, probing and minimal verbal as well as non-verbal responses. During the interview the researcher used bracketing (putting preconceived ideas aside) and intuiting (Burns & Grove, 2001:80).

A high quality audio-tape recorder was strategically placed to capture all dialogue between the researcher and the participant. These interviews were audiotaped and later

transcribed (with permission from the respondents). Interviews were conducted until the data was saturated as demonstrated by repeating themes.

2.4.2.2 Narrative diary

Parents were requested to complete a narrative report on their experiences of their child's hospitalisation in the paediatric unit. Parents were able to describe incidents that shaped their experiences on a daily basis as often as they wished. Parents were requested to hand these back on the day of discharge. The diaries did not identify the parents and participation was voluntary. Parents' narratives provided helpful perspectives related to their experience and rich detail about their feelings and thoughts.

2.4.2.3 Field notes

Unstructured observation on the part of the researcher was also used as a method of data collection. The researcher attempted to describe behaviours as they were observed, with no preconceived ideas, in the field notes that were kept. The researcher wrote field notes (observational, theoretical, methodological and experiential) in a field diary during and after the interviews as a measure of triangulation.

2.4.2.4 Conceptualisation

The results of the research study were discussed in light of available literature and information obtained from similar studies. The findings from a phenomenological study are compared and combined with findings from the literature to determine current knowledge of the phenomenon (Burns & Grove, 2001:725). The purpose of a literature study is to confirm findings and integrate the findings of this research study into existing frameworks. The experiences of parents during their child's hospitalisation in a private paediatric unit were therefore incorporated with existing knowledge, thus making the findings more meaningful.

Various criteria were applicable to the literature used in this research study. These criteria are briefly explained below:

- P*rimary sources* of literature were used in the research study. Primary sources of literature are written by the persons who conducted the relevant study and whose findings are described. Using only primary sources avoids possible incorrect paraphrasing that may occur by authors who summarise the research findings of others, thus generating secondary sources of literature (Burns & Grove, 2001:107).
- *Empirical literature* was used for the conceptualisation and conceptualisation phase of this research study. Unpublished studies, as well as articles that appeared in relevant journals were considered.
- Where possible, both national and international articles and sources were used for the conceptualisation and conceptualisation phase. The use of national articles allowed for the findings of this research study to be functional and relevant to South Africa. By incorporating both national and international literature sources, it was ensured that the study has a wider field of reference.
- Electronic databases were also used to locate articles that are available on the World Wide Web. Library catalogues were enlisted to find appropriate hard copies of articles in journals and other published sources (Burns & Grove, 2001:110).

The literature is presented at the end of the study and it becomes a basis for comparing and contrasting the findings of this study. It was performed after the data had been analysed and coded. The results, differences and similarities in the narrative form were compared with the theories and literature.

A list of titles for all sources used was included in the bibliography. Referential checks enhanced the scientific trustworthiness of the study. This was a strategy used to ensure trustworthiness by means of triangulation.

2.4.3 Data analysis

Data analysis is the organising of raw data and displaying it in a fashion that will provide answers to the proposed research questions (Brink, 2001:178). It entails categorising, ordering and summarising the data and describing the data in meaningful terms. Analysing

data usually involves two steps: the first part is to reduce to manageable proportions the wealth of data one has collected or has available; and the second is to identify patterns and themes in the data (Mouton, 2002:160).

Transcribed interviews, narrative sketches, field notes and samples of human action are treated as text analogues for interpretive analysis. Tesch's method of open-coding (in Cresswell, 1994:155) was used to conduct content analysis. Steps included in this method were:

1) reading carefully through all transcripts in order to get a general overall feeling for the transcriptions;
2) randomly choosing one transcript and reading through it, jotting down ideas in the margins on the transcript as they come to mind and answering the following questions: "What is it about" and "What is the underlying meaning?";
3) repeating the previous step for all transcripts, and then making a list of all topics listed in the margins, clustering similar ones together, and then drawing up three columns marked 1) major topics, 2) unique topics and 3) leftovers;
4) finding the most descriptive wording for topics and turning them into categories, grouping related topics together and drawing lines which indicate an inter-relationship;
5) making a final abbreviation for each category and alphabetising these codes;
6) assembling the data material belonging to each category in one place and performing a preliminary analysis. (It is important to note unusual or useful quotes that can be later incorporated into the qualitative story. Major and minor themes can be categorised and another list can then show contrasting themes.);
7) re-coding the existing data if necessary.

The above-mentioned protocol was sent in a sealed envelope, together with a blank transcription (i.e. one where no coding has been done in the margins) to the independent coder. Thereafter a meeting was held for consensus discussions on the categories which were reached independently. After agreement had been reached on the major and underlying themes, the results were presented in chapter three of this research study.

2.5 TRUSTWORTHINESS

The worth of any research endeavour is evaluated by peers and readers. In order to secure a positive evaluation, measures to ensure trustworthiness have to be applied. Guba proposed a model for assessing the trustworthiness of qualitative data (Guba & Lincoln, 1995:301). Guba's model was chosen because it is comparatively well developed conceptually and has been used by qualitative researchers, particularly nurses and educators for a number of years (Krefting, 1991:215).

The model is based on the identification of four aspects of trustworthiness: truth-value; applicability, consistency and neutrality (Guba & Lincoln, 1985:301).

2.5.1 Credibility/truth-value

Truth-value is obtained by discovering accurate descriptions of phenomena as they are lived and experienced by the participants of the study. It is subjective data that needs to be obtained. The emphasis of this study was the understanding of experiences, the truth-value of the study was of utmost importance.

Another term that is used by Guba is credibility. This is achieved when others in the same fields as the one studied, recognise and share the phenomenon described in the research study (Guba & Lincoln, 1985:301). Sandelowski (in Krefting, 1991:216) suggested that a qualitative study is credible when it presents such accurate descriptions or interpretations of human experience that people who also share that experience would instantly recognise the descriptions.

2.5.1.1 Prolonged field engagement

Activities in achieving credibility were related to prolonged field engagement. Prolonged field engagement was important for identifying and documenting all possible patterns and themes occurring in the particular phenomena. Prolonged engagement also allowed the respondents (in this study, the parents) to become used to and familiar with the researcher. This prolonged engagement hopefully prevented the Hawthorne effect (Burns & Grove, 2001:41). When the researcher had prolonged engagement with

participants, it allowed the researcher to identify inconsistencies in the respondents' responses. These inaccurate responses could be based on social expectations rather than on personal experience.

Observation of the phenomena in all natural settings, across the timespan that the phenomenon is occurring, was also important. This was ensured by the researcher being present in the unit for the majority of the child's stay in the unit, and when the researcher could not be present, by providing parents with narrative diaries, wherein parents could record their experiences on a daily basis.

2.5.1.2 Reflexivity

Reflexivity refers to the assessment of the influence that the researcher's own background, perceptions and interests have on the study. This was an important aspect as the close relationship between researcher and parents (created by prolonged exposure in the field and observation in the natural setting) that is so important for an accurate insight into a phenomenon could have led to the researcher not being able to accurately interpret the data (Krefting, 1991:218). In order to counteract the possible over-involvement, a field journal was kept by the researcher. Making use of the field journal, the researcher kept a record of her own behaviour, experiences and reflections on her thoughts, feelings, ideas and hypotheses generated by the data collected to date. When the researcher observed any possible biases, she was able to review the approach taken to collect or analyse the data (Krefting, 1991:219).

2.5.1.3 Triangulation

Triangulation is the combined use of two or more theories, methods, data sources, investigators, or analysis methods in the study of the same phenomenon (Burns & Grove, 2001:239). Multiple data sources and contexts were preferred in order to create a more naturalistic account and to prevent an overly narrow perspective of the situation (Benner, 1994:119). In this study, field notes, narrative diaries and unstructured individual interviews were methods used to achieve data triangulation. The interviews continued until there was data saturation and the participants had nothing further to add. The researcher also spent time in the paediatric unit observing the interactions and

activities that took place within the unit. The intention was to provide a means of cross-validating the findings (Burns & Grove, 2001:241).

2.5.1.4 Interview technique

The interviewing technique also enhanced the credibility of the study. Kvale (1983:171) discusses the aim of the qualitative research interview as obtaining as many nuanced descriptions from the different aspects of the respondents' life-worlds as possible. Precision in description and stringency in meaning interpretation were important for credibility. The rephrasing of questions, repetition of questions, or expansion of questions on different occasions were ways in which credibility was increased (May in Krefting, 1991:220).

2.5.1.5 Peer group discussion

Peer group discussion involves the researcher discussing the research process and findings with impartial researchers who have experience in qualitative studies (Krefting, 1991:219). In this research study, a supervisor and co-supervisor, both with doctorate qualifications and extensive qualitative research experience, were reviewing the research during all its phases.

2.5.2 Transferability/applicability

Applicability is the degree to which the findings of the research study can be applied to other contexts and situations. It is the ability to generalise the specific findings to explain a larger group's experience (Krefting, 1991:214-222).

Transferability is the criteria against which applicability is measured in a qualitative study. It is the ability to transfer findings to another similar situation. Transferability was achieved by a dense description of the data and purposive sampling (Guba & Lincoln, 1985:301).

2.5.2.1 Dense description

It is important that dense (or complete) background information regarding the context and the sampling methods be given, so that other researchers can assess the transferability of the findings.

2.5.2.2 Nominated sample

In this study a complete description of the method to be used for conducting the interviews was given, as well as the setting of the interviews and a complete description of the population and sampling method used. This provided future researchers with the necessary information to replicate the setting and research.

2.5.3 Dependability/consistency

In assessing whether or not similar results would be obtained if the study were done again with the same people or in a similar situation, consistency was proven. As qualitative research does not control the variables, but emphasises the uniqueness of individuals' perceptions, variations in experience, rather than identical results are expected (Krefting, 1991:216).

As a result of this variability, consistency is defined in terms of dependability. Guba's concept of dependability implies trackable variability, that is variability that can be ascribed to various identifiable sources (Guba & Lincoln, 1985:301). The authors mentioned used the term auditable to describe the situation in which another researcher can clearly follow the decision trail used by the researcher in the study.

2.5.3.1 Dense description of research method

Dependability was achieved by a dense description of the method of data gathering, data analysis and interpretation (Krefting, 1991:221).

2.5.3.2 Co-coding of data

Another way of increasing the dependability of the study is for the researcher to conduct a code-recode procedure on the data. This implies that the researcher codes the data, then two or more weeks later, recodes the same data and compares the findings. In this study the data was sent to an independent coder and the findings compared for similarities and differences.

2.5.4 Confirmability/neutrality

Neutrality is the freedom from bias in research procedures and results. The findings should therefore be a true reflection of the subjects' experiences, and not a reflection of the researcher's biases. Neutrality refers to the degree to which the findings are solely a result of the information and the conditions of research and not of other biases, motivations and perspectives (Krefting, 1991:216).

The criterion for measuring neutrality is confirmability. This is achieved when truth-value and applicability are established. Confirmability in this study was achieved by ensuring reflexive analysis and data analysis triangulation (both methods have been previously described) (Krefting, 1991:221).

As can be seen from the above descriptions all four these aspects of ensuring trustworthiness are interlinked and were all present in order to achieve a favourable evaluation by peers and readers.

2.6 CONCLUSION

In this chapter the research design and method, as well as the mode of trustworthiness have been described in detail.

Following the above-mentioned procedures, the lived nursing care experiences of parents during the hospitalisation of their child were accurately captured and portrayed.

In chapter 3 the research results of the parents' experiences of their child's hospitalisation are presented and discussed.

CHAPTER 3

Nursing care experiences of parents regarding the hospitalisation of their child

3.1 INTRODUCTION

Chapter 2 discussed the methodology that was followed in this research study. The purpose of this chapter is to describe the nursing care experiences of parents regarding the hospitalisation of their child in a private paediatric unit.

As illustrated in Table 3.1 the nursing care experiences of parents are categorised in main categories, subcategories and themes. The results were described and interpreted in more detail in accordance with the table. The results are supported by verbatim quotes from the participants, obtained from the interviews, and narrative diaries that were used, and are further supported by the researcher's field notes and observations, as well as relevant literature.

3.2 EXPERIENCES RELATED TO THE INTERACTIVE PROCESSES WITHIN THE PAEDIATRIC UNIT

The findings regarding parents' experiences of their child's hospitalisation relate to various interactive processes within the paediatric unit. These interactive processes have to do with **parental participation** in the care of their child, experiences related to certain **unit management dimensions** in the paediatric unit and **communication** between parents and nursing care personnel.

3.2.1 Parental participation

Parental participation has been pointed out as an important aspect of what parents' experiences of the hospitalisation of their child. Experience of parental participation relates to parents' *willingness to participate in the care* of their hospitalised child, *barriers to parental participation* such as feelings of guilt, power-relations and

TABLE 3.1: Nursing care experiences of parents regarding their child's hospitalisation

MAIN CATEGORY	SUBCATEGORY	THEME	SUBTHEME
Experiences related to the interactive processes in the paediatric unit	Parental participation	• Parents willingness to participate in their child's care	• Empowerment of parents to participate in certain aspects of care
		• Barriers on the extent and intensity of parental participation in their child's care	• Parents' feelings of guilt as a barrier in parental participation in child's care
			• Challenges caused by parents' social roles
	Unit management dimensions: Planning and organising	• Experiences related to family education activities in discharge planning	• Preparedness of parents for discharge
		• Experiences related to aspects of organising the paediatric unit routine	• Provision of quality nursing care
		• Experiences related to organising of resources in the paediatric unit	• Stock availability
			• Cost containment
	Communication in the paediatric unit	• Experiences related to interpersonal relationships	• Parents – nursing care professional relationship
			• A trusting relationship
		• Experiences related to caring in the paediatric unit	• Physical gestures of affection and sensitivity
			• Lack of basic nursing actions
		• Experiences related to information management in the paediatric unit	• Communication flow in the paediatric unit
			• Relevant information
			• Communication style
Experiences related to the environment of the paediatric unit	Creating a therapeutic environment for parents	• Experiences related to facilities available	• Rooming in facilities
			• Nutritional needs of parents
		• Creating a safe environment for parents	• Parental general comfort
			• General hygiene

challenges because of parents' social roles, which are further influenced by the *intensity of parents' participation* in the care of their child.

3.2.1.1 Parents' willingness to participate in their child's care

Parents demonstrated a willingness to participate in caring for their child as the following excerpt indicates:

"Your baby knows you better than the nurses. So if you are with your baby then the baby doesn't have much problems, so to be with your baby I think it is a fine thing"

The aforementioned finding of parents' willingness to participate in the provision of care to their child has also been observed by the researcher from her own experience and interaction with parents with children in paediatric units. Parents further indicated that if nursing care personnel, and in particular nurses, **empower them** to participate in the care of their child, it contributes to positive feelings within them. The following excerpt from the data supports this observation:

"I watched her getting better all the time, and that makes it all worthwhile for me"

The question that must be asked is "Who empowered the parents to act on the nursing personnel's behalf"? Newton (2000:164) indicated that the concept of parental participation in the care of the child has become a central tenet of paediatric nursing for the 21st century. To this effect, nursing care interventions, such as in-hospital and home-based care, have shifted to recognise families' involvement in care as central to a child's care.

Parents' involvement with the care of their child not only contributes to positive feelings within parents, as has been shown by this research, but Hallström (2004:n.p) indicates that strengthening parents' involvement in the provision of care to their child, enables parents to take on greater responsibility and increases their sense of being in control. This, in turn, not only contributes to the parents' well-being, but, as bonding experts have always indicated,

these positive feelings parents experience while participating in the care of their child, are used by nurses as a starting point to promote the well-being of the child. In addition, Hallström (2004:n.p) points out that allowing parents to have a voice in the care of their child, makes parents feel that they are part of the nursing care team which provides quality care to their child during his/her hospitalisation. Knafl et al., (1988:97) are also of the opinion that parental participation is dependent on control and negotiation. They rightfully point out that a balance should be struck between the control a nurse has over the care of the child and that of a parent. For example, they indicate that problems can occur when parents exert too much control over the hospitalisation of their child. To remedy such as problem, they indicate that negotiation is important. Negotiation will imply that the nurse and parents will, together in a mutually respectful and sensitive way, discuss the care of the child to the advantage of the child.

Parents' willingness to be involved in the care of their child relates further to **certain aspects of care**, such as administering medicine to their child, feeding, bathing and entertaining the child. The following excerpt from the raw data can be provided as a qualification for the aforementioned observation:

"…they didn't wake him up for his medicine… and then I gave it when he woke up"

Knafl et al., (1988:101) discusses three categories of care activities which also include the nurturing activity as pointed out in the aforementioned quote. Knafl et al., refer to nurturing activities, medically related activities and housekeeping activities as possible activities in which willing parents can participate. Nurturing activities refer to activities such as comforting and giving emotional support to their child, entertaining the child, feeding, bathing and brushing the child's teeth. Medically related activities include activities which relate more to the medical treatment of their child, such as accompanying their child to x-rays or during a procedure, taking vital signs, noting skin colour and helping with changing bandages. Housekeeping activities relate to the physical environment of the child, such as changing and making of beds.

It could be concluded that parents should be supported with the hospitalisation of their child by empowering them to partake in certain aspects of care. In paragraph 3.2.1 it was mentioned that parents experience certain barriers that hinder their participation in the care of their child. These barriers will now be discussed.

3.2.1.2 Barriers on the extent and intensity of parental participation in their child's care

Two barriers have been identified in the data that hinder parents from participating in the care of their child during hospitalisation. These barriers relate to *feelings of guilt* experienced by parents and *challenges posed by parents' social roles*.

Even though parents have demonstrated a willingness to participate in the care of their child during his/her hospitalisation, they verbalise that they experience intense feelings of guilt. Feelings of guilt are often attributed to parents who are not allowed into the procedure room during procedures by nursing care personnel. The following quote from the interview data qualifies this observation:

"The worst was when they told me I wasn't allowed to go with her when they put the drip in. Said I should go have a cup of coffee. That was really silly, I thought. What mother can leave her child while they hold her down and hurt her?"

Furthermore, feelings of guilt experienced by parents have been related to the pain and suffering they perceive their child to have gone through, and that they were not allowed to comfort him/her. The following quote is evidence hereof:

"One morning the sister said she was just going to inject straight out of the syringe, one, two, three and it was over. He screamed and she held him down with her one arm and injected with the other. He is so small, he couldn't move, so he just screamed. I feel that was terrible"

Parents' feelings of guilt can also be attributed to the fact that they feel they did not spend enough time with their child. The following quote supports this observation:

"Although a lot of things were done in my absence… because, I was probably… I didn't spend a lot of time with the child…"

Parents therefore felt guilty if they were unable to spend large amounts of time with their child in hospital. One of the reasons for not being able to spend the desired amount of time with their hospitalised child was challenges caused by parents' social roles.

During a child's hospitalisation there are various reasons for parents not spending large amounts of time with their child, and often parents' social roles contributed to this.

Parents often had to leave their child during the child's hospitalisation due to work commitments. The following extracts indicate the burden that work responsibilities place on parents' ability to participate in their child's care:

"And I can't sit next to his bed all the time, I have to work"

"I didn't spend a lot of time with the child and can only come at certain times"

However when it was possible, parents did take leave to spend time with their child during their child's hospitalisation. The following statement is evidence of this:

"I took leave from work and stayed with him all the time"

Parents also feel torn between their own needs and the needs of the hospitalised child. However at times it was necessary for parents to "take a break" from it all, as the excerpt below shows:

"… You need to get out of here too, you can't just sit in these four walls, and it gets a bit too much…. And life goes on out there"

The hospitalisation of a child can cause a lot of stress for the parent and therefore also in the family. So far it has been shown that parents demonstrate a willingness to participate in the care of their sick child. Certain factors that function as barriers can hinder parental participation in care. Hospitals, as environments with a particular culture which sometimes is contrary to the culture of the people they serve, can be quite challenging. Therefore, it is of utmost importance to manage hospitals in such a way as to make the hospitalisation experience of children and their parents more positive. To this effect, the management style and processes operating in a particular unit determine the culture within that unit which in turn can contribute to certain experiences of those who are in interaction with that unit.

In conclusion, it was found that the barriers regarding the extent and intensity of parental participation in the child's care are twofold, namely parents feelings of guilt and challenges caused by their social roles. Parents should be supported, by the nursing personnel, to deal with feelings of guilt and the challenges caused by their social roles, with the hospitalisation of their child.

The second subcategory of experiences of parents whose child has been hospitalised has to do with their experience as they relate to the management of the paediatric unit.

3.2.2 Experiences related to unit management dimensions: planning and organising

Muller (2002:104) defines unit management as the utilisation of the following managerial activities: planning, organising, leading and control. The purpose of these activities is the achievement of the objectives of the nursing unit.

Parents verbalised that various facets of unit management had influenced their experiences of their child's hospitalisation. Many of these experiences of parents about the hospitalisation of their sick child related to the planning and organising of care that

included *family education activities in discharge planning,* the *resources management* in the unit and *unit routine*.

3.2.2.1 Experiences related to family education activities in discharge planning

Planning refers to a process whereby the nurse who acts as a manager of patient care in the unit, assesses, analyses and prioritises care activities in such a way to achieve a particular outcome (Muller, 2002:105). Parents narrated their experiences of particular activities that relate to the planning phase of the unit management process. One of these outcomes that was not adequately met was parents' experiences about family-education activities during discharge planning.

Parents' experiences about family-education activities have to do with discharge activities. Discharge can be viewed as a process, starting with the admission of the patient, and is meant to include a range of activities, which includes family-education.

Parents verbalised their experiences of discharge activities as mixed experiences, with some being forewarned and having ample time **to prepare** for it, whilst others were very inconvenienced by poor planning and lack of communication regarding the expected discharge of their child.

Parents gave an indication that the discharge of their child had been discussed with them and that they were well aware of the expected discharge date, as well as the continuation of care at home. The following is an example of this preparedness:

"Dr X said we can go home tomorrow probably, and then he will just continue with antibiotics at home"

"The doctor eventually arrived at 19:00 and said he could only go home the next day"

Lack of information regarding discharge date and time, and having to make arrangements at very inconvenient times made parents very angry, and this increased the feeling of frustration experienced. The following statement is evidence of this:

"We only went home the next night you know, when he (the surgeon) *was finished in theatre"*

Delays can be prevented if discharge planning also took logistics into consideration, and this again highlights the importance of communication between doctors, nursing personnel and the parents. The following indicates how the lack of logistic consideration affects discharged children and their parents:

"Where must I find transport at that time… and then I had to pay extra, because there are so few taxis"

By carefully planning family-education activities and the child's discharge, cost containment can once again be accomplished as bed days were minimised by parents not having to stay longer to arrange for transport and for meetings with other members of the multi-disciplinary team.

The discharge day is often the highlight of the parents' and child's hospitalisation process, and is keenly looked forward by parents and patients alike. Often the last impression parents have of their child's hospitalisation is the discharge day, and it is thus very important that nursing personnel make a positive lasting impression of the paediatric unit by ensuring that parents have ample warning of their child's discharge and that they have received ample family-education prior to discharge.

In concluding the findings on discharge planning, it was evident that parents should be supported to be prepared and informed when the child is to be discharged.

3.2.2.2 Experiences related to aspects of organising the paediatric unit routine

Organising in nursing can be defined as "the orderly structuring and division of duties, tasks and responsibilities with a view to ensuring the smooth running of activities in the unit". It creates order in the unit, and facilitates quality, efficiency and effectiveness (Muller 2002:138). Put otherwise, it defines a routine way of working, to ensure "the job gets done". Muller (2002:127) defines unit routine as "referring to the standardisation of the daily functions and activities in the nursing unit to facilitate quality nursing care and optimal utilisation of personnel, time and other resources".

Parents had many experiences of amalgamating their own routines into that of the private paediatric unit. The unit routine clearly influenced parents' experiences of their child's hospitalisation in the paediatric unit of a private hospital. These routine activities often hindered parents' nurturing of their child as the following excerpt regarding this aspect shows.

During an interview with a parent a probing question was: "How did the unit routine influence you?"
"That was fine. . . . There were other mothers who said they must leave the children because they felt in the way of nurses, but I felt it was fine because that's why she is here…"

Quality nursing care was, however, not experienced by all the parents in the paediatric unit. Parents mentioned that, often, their child's basic needs have not been met. The following quotes are provided in support of this observation:

"Poor child hadn't been bathed…"

"At least they could have washed him"

When parents felt that their child's most basic needs were not being met, they immediately became angry. However, there were instances where basic nursing care left a very positive impression on the parents. The excerpt below is evidence of this:

"Her bed was changed a lot, more than at home actually, when it just looked dirty the linen was changed. Everything and everyone is very neat here."

Parents place a lot of emphasis on the provision of **quality care** to their child and the meeting of their child's basic needs. In conclusion, the challenge for nursing personnel is to support parents in being satisfied with the unit routine. This lies in the provision of this quality care within a managed nursing care environment, where the emphasis is on resources management and cost containment.

3.2.2.3 Experiences related to organising of resources in the paediatric unit

Managed nursing care is a growing reality in the South African nursing care system and influences the utilisation and cost of services in order to facilitate cost-effective quality care to medical aid members. Areas in nursing care that account for the greater portion of the expenses of a nursing unit include supplies and equipment. The nursing unit manager has a responsibility to become involved in the financial management, including stock and equipment control, as well as the introduction of cost containment that is in keeping with the culture of managed care found in the majority of private hospitals (Muller, 2002:190). The availability of resources has a significant impact on the delivery of patient care.

In this study parents identified **stock availability**, as well as the implementation of **cost-containment** measures as two important aspects of resource management that affected their experiences of their child's hospitalisation in the paediatric unit of a private hospital. In this regard, the availability of stock was highlighted as a point of concern. Often the unavailability of stock reflected poorly on the planning ability of nurses to pro-actively identify and decide how much stock is needed. Parents then took it upon themselves to

ensure that the stock their child needed was made available. One parent voiced this as follows:

"… [They] *don't keep whatever injection as unit stock… and it hasn't come from the chemist yet… I went myself to the chemist and got his medicine"*

"… Why do you pay so much for a hospital and medical aid if the nurses can't do their work properly? Then let us pay less and we can do the work ourselves"

The lack of availability of resources such as stock in a paediatric unit, can hamper the quality of care delivered to children. This, however, is not in the same vein as managed nursing care which strives to ensure that quality care is provided to patients (Mahlo & Muller, 2000:37).

The researcher has observed that stock availability is dependant not only on the timely ordering of stock, but also on the delivery of stock by the pharmacy. There is not always enough personnel to ensure that the prescription chart is immediately delivered to the pharmacy, and even if it were to be delivered, the pharmacy works at its own pace which is seldom hastened by nursing personnel's requests. Whilst it can not be expected of the paediatric nursing unit to stock all possible medications within the unit, it is reasonable to expect the nursing function to be supported by all other departments within the hospital, and that includes the pharmacy department, which is indeed responsible for the issuing of prescribed stock (Booyens (ed), 1998:153).

The organising of resource management is only one of the aspects of organising within the unit that parents were not satisfied with during their child's hospitalisation in a private paediatric unit. Another closely associated aspect is that of cost containment.

Considering that the study had been conducted in a private hospital, cost-containment or managed care activities brought about certain experiences in parents whose children have been hospitalised in this unit.

Parents often felt that they are being used for financial gain. Often the parents whose child has been hospitalised in the unit experience that nursing care personnel place their greed for money before the needs of the child. One parent in particular voiced it as follows:

"Then he [the surgeon] *obviously decided the money was too much to lose and came out…"*

These experiences often outraged parents as they felt that the greed of certain nursing care personnel amounted to robbery which jeopardised the health of their child. One parent voiced her anger and outrage as follows:

"The doctor mustn't think I am paying his fees, I wont."

"Neither of them better send me any accounts… I won't pay you know. Robbery"

Nursing personnel are increasingly being called upon to contain costs and still provide high quality nursing care. Suggestions for nursing personnel for promoting cost containment include doing a job effectively, motivating patients to recover, using stock carefully and maximising the use of their time (Nagelkerk, 1996:28).

Managed nursing care has been introduced over the past years to ensure that cost-containment measures are implemented without jeopardising the quality of care given to patients (Muller, 2002:197). This movement was initiated by medical aids and should now be an accepted policy and "way of life" in private hospital settings.

Users and funders of nursing care services, such as parents, are beginning to state explicitly the kind and quality of nursing care delivery that they expect from nursing care services. It is not unheard of for patients to complain to their medical aids regarding the quality of care they received at a hospital or, more specifically, the unit they were admitted in, and as funders of nursing care have contracts with nursing care services regarding the treatment they expect, it is a breach of contract if services are not delivered as contractually

stipulated. This has led to an increase in court cases and refusal to pay for services provided by nursing care services (Booyens (ed), 1998:599).

Stock availability and **cost containment** is vitally important in a private paediatric unit and all nursing personnel should make sure that they perform their care in the most effective manner possible, while ensuring that quality care is not compromised in any way. While it is not possible to ensure that the doctors overseeing the patient exercise cost management, it is important that nursing personnel maintain their part in managed nursing care. This can be done by making sure that all necessary stock is obtained as quickly as possible and that the patients receive the highest level of expected care. This will have financial implications for the unit, as well as a direct influence on parents' satisfaction with the care received in the private paediatric unit.

In conclusion, unit management dimensions of planning and organising in the private paediatric unit should be addressed. Feelings of anger and distrust amongst parents, that were related to organising resources and cost containment should be combated through support to parents. The second theme is related to the unit routine and a discussion follows.

Experiences of parents relating to the planning and organising aspects of unit management were described, including family-education activities with regard to discharge planning, unit routine and resource management. The third and last category of parents' experiences of the interactive processes within the private paediatric unit related to the process of communication.

3.2.3 Experiences related to communication within the paediatric unit

The importance of communication should never be underestimated as this could impact significantly on parents' experiences of their child's hospitalisation in a private paediatric unit. Parents' experiences of communication within the private paediatric unit related to *interpersonal relationships, caring* and *information management*. These three themes are very closely linked and at times it is difficult to separate them from one another.

3.2.3.1 Experiences related to interpersonal relationships

Interpersonal relationships are essential in nursing. If harmonious interpersonal relationships do not exist between nursing care personnel, patients and family, patient safety and the quality of care being offered are threatened (Searle, 2000:206). The extract below is an example of how a disharmonial relationship can cause parent dissatisfaction and affect the quality of care delivered:

"I refused to sign consent and that was an issue, because the surgeon wanted to operate and he was "scrubbed up" and refused to come into the theatre reception area to tell me what he wanted to do. So I said I am taking my son to another hospital"

All interpersonal relations are built on a certain amount of **trust**, and the parent-healthcare professional relationship is no different. Trust is the key to the contractual relationship between parents and nursing care personnel. Parents should trust the nursing personnel and this could enable them to leave their children in the unit.

Parents appeared to be at ease and experienced the unit and personnel as generally trustworthy. The following statements are evidence of this:

"I am not asking myself how are these people probably caring for my child, how is the care, even if I am not here I am 100% satisfied that she is in good hands"

"They build good relationships with the child and you don't feel bad to leave them alone here…"

Parents' experiences of interpersonal relationships were both positive and negative, but the effect of these relationships on the overall experience of a child's hospitalisation in a private paediatric unit should not be underestimated. In conclusion, the findings indicate

that parents should be supported during the hospitalisation of their child through a trusting relationship between the parent and the nursing care professional.

Caring and information management were the other two themes of communication that were identified in the interviews relating to the experiences of parents.

3.2.3.2 Experiences related to caring within the paediatric unit

Nursing is the major caring profession in the world. The primacy of the caring role in nursing is the core of nursing practice (Searle, 2000:92). Said otherwise, caring is the essence of nursing.

Nursing care personnel who pay attention to the physical and emotional needs of their patients have been described as caring. Below are excerpts from the individual interviews, indicating parents' experiences of caring nursing care personnel who, through their **physical gestures,** showed affection and sensitivity to the parent and child:

"They are very gentle with her…"

"The sisters and doctors, their hands are hot and they make my child happy"

"Sister is perfect, is working nicely and the hands are nice to my son, and when they talk to me they talk nicely. So everything is nice here, and they talk to me nice"

Parents however did not all experience acts of caring in the unit. The omission of these acts of caring, at times, left parents feeling especially disgruntled. Omission on the nursing personnel's part to attend to basic needs, such as seeing to a child's personal comfort, can portray the personnel as being uncaring and not taking an interest in a child's welfare. This leads to anger on the part of the parents which is not unjustified. Below are statements which show how **lack of nursing actions to address basic needs** can sour the nurse-parent relationship:

"Poor child hadn't been bathed, he was injured playing rugby for s@#t sake, and he was full of grass and dirt on his legs. His feet were filthy, even under his nails, but they [unit nursing personnel] *hadn't even bathed him"*

"No one came to talk to him, no one felt his fingers or moved them, or checked he was comfortable"

"I think they just don't care. He is not a difficult child you know, but he stays my child".

As can be seen from the above, parents place a lot of value in caring behaviour, and an abundance or lack thereof can be a deciding factor for parents when choosing a hospital that they wish to be admitted to themselves, or in which they would like their children to be admitted. Evidence of caring behaviour is a strong predictor of client satisfaction. In a private hospital setting client satisfaction can increase revenue with patients returning to the same hospital for further treatment, as well as lower legal costs. Parents who are not satisfied are less likely to return to the same hospital, and therefore the importance of caring behaviour cannot be emphasised enough.

In conclusion, the experiences of parents indicate the need for caring and support that should be provided to parent and child in positive physical gestures of affection and sensitivity, as well as basic nursing actions.

The last theme of communication that parents experienced was that of information management in the private paediatric unit. These experiences will now be discussed below.

3.2.3.3 Experiences related to information management in the paediatric unit

Parents' experiences of the information management used in the unit, differed within the private paediatric unit. Here is a communication network, with its own dynamics, which parents experienced differently.

Parents experienced the **lack of communication flow** between doctors and themselves as a source of irritation, and they experienced anger and frustration at the delays which resulted from poor communication. It appeared as if the nursing personnel formed the link between the doctors and parents, and parents recognised this, and thus did not blame the nursing personnel for the lack of communication and **relevant information** between the doctor and themselves. The following statement is evidence of this:

"… the surgeon was told about the case at 16:30, and at 20:00 still hasn't arrived to see my son, nor has he seen my child's x-rays"

Information communicated has the ability to empower parents and to allow them insight into their child's condition, as the following two statements show:

"the doctor tell me on Tuesday,… then he went to X-ray and that he has flu"

"I wouldn't have thought anything about it, but one of the sisters said it must be in a bag and take an hour because it was such a large dose and it would burn too much"

Another pattern of interaction that can be linked to communication and information management has to do with the lack of information experienced by the parents. Parents who were unable to see or speak to the nursing care practitioner (in this case the doctor) became very angry at the lack of information received. The following statements are evidence of this:

"How can you just tell a parent that they must sign consent without anyone coming to talk to me about what was going to be done?"

Parents experienced a lack of information as a factor that contributed negatively to their emotional safety. It also caused a lack of trust. The following statement is proof of this:

"And the doctors should have seen him, not just take the casualty doctor's word about what was wrong with my son's arm. What does he know, he's not the specialist"

Parents had a need to communicate with their spouses and this was a method of communicating information that the parent had received from another source of information. The following is evidence of this:

"Yes I did, and I tell my husband, the sister is perfect…"

"And then I phoned back to my husband"

Parents experienced the **communication style** between the nursing personnel and their child as very important. Once again there are extremes of experiences, some being positive and others negative. Communication contributes to parents trusting the nursing personnel enough to leave their children alone with the personnel. The following statements are evidence of the positive responses:

"… and talk to her and distract her the whole time…"

"They build good relationships with the child"

When nursing personnel did not communicate optimally with their child, parents were quick to identify it, as the following statements show:

"She didn't even talk to him, just told him not to cry 'cause he was going to wake the other children"

"No one came to talk to him"

In conclusion, parents wanted hospital personnel to communicate with themselves and their child in the process of providing care. Parents observed personnel for signs that indicated

that they (the healthcare personnel) have compassion for the parents and their children. Parents desired an interactive relationship of communication flow with the personnel that not only communicated information regarding their child's care, but that also displayed a communication style of compassion, understanding and somehow sensed the parents' or child's needs (Stratton, 2004:4).

When enough information is given to parents, parents feel empowered and able to be an advocate for their child's health. Information, not only from the nursing care personnel, but also from the doctor, is valued by parents.

This study has highlighted that parents having received adequate information regarding their child, respond much better to their child's condition and are more co-operative. Information communicated correctly assists parents in becoming more empowered and competent. However, when there is a communication breakdown in any form, parents' experience turns very negative and this negatively colours their entire experience of their child's hospitalisation in a private paediatric unit.

The value of open and clear communication and information transfer between parents and nursing care personnel cannot be underestimated and should receive attention from all levels of unit management to allow parents to have a more enriching and empowering hospitalisation experience.

Parents' experiences of the interactive processes within the private paediatric unit included themes such as parental participation, dimensions of unit management, as well as communication. It should, however, be remembered that all of these experiences took place within a specific environment, namely the private paediatric unit.

3.3 EXPERIENCES RELATED TO THE ENVIRONMENT OF THE PAEDIATRIC UNIT

Parents who spent the night with their child during the child's hospitalisation in a private paediatric unit were greatly influenced by the environment in which they found themselves.

3.3.1. Creating a therapeutic environment for parents

The parents' experiences can be categorised according to the *facilities available* to them, as well as *creating a safe environment for parents.*

3.3.1.1 Experiences relating to facilities available

Parents experienced the lack of **rooming-in facilities** as an inconvenience, and whilst none of the parents expressed anger, it was clear that more comfortable, convenient and peaceful facilities for parents wishing to spend the night with their child would have been welcomed by parents (and paediatric patients). The following extracts are evidence of this:

"it is just the sleeping on the couch; I don't know they must try something that will make you feel comfortable at night you see".

"Try to do some beds, something for the mom's and the babies"

"In the past I would have stayed in a bed, this time I only had a chair. First those hard green ones, but from the second night they gave me a lazyboy chair, and that was a bit better … it was difficult getting proper food for myself"

Not only were physical sleeping facilities important for parents but also, as mentioned in the above quote, **nutritional needs** of parents staying with their children. The below quotes indicate this:

"Maybe supply food to the parents if they have infants that need 24/7 care"

"Mothers should be able to get food at least while looking after their babies"

"We think one should be able to order meals and tea/coffee at a minimum price"

Facilities, not only for sleeping, but for **parental comfort in general**, were also questioned by parents. Below is a comment from a narrative diary that supports this:

"Badkamer is koud en lazyboys is te min"
[Translation: Bathroom is cold and lazyboys too few]

Facilities that parents also found to be less than optimal were those put in place to make parents' stay more enjoyable and convenient. However, they appear to have had the opposite effect as the quotes below indicate:

"the phones were not accessible; this was a great inconvenience"

"Die TV remote werk nie"
[Translation: The TV remote doesn't work]

"TV opvangs is baie swak"
[Translation: TV reception is very bad]

"Lig in toilet is buite werking"
[Translation: The toilet light is out of order]

In conclusion, the findings indicate the need to support parents with the necessary facilities during their child's hospitalisation. Parents would have preferred more comfortable rooming-in facilities and equipment that is in working condition for general comfort. The nutritional needs of parents should also be addressed or attended to during their stay with

their children. Providing better facilities for parents to have a more comfortable stay is necessary to be done to create a therapeutic environment for parents.

3.3.1.2 Creating a safe environment for parents

The parent should be viewed as an important role player in caring for the hospitalised child. Thus the therapeutic environment in the unit should be safe to facilitate parents' physical, psychological and social needs.

Noise has been described as one of the most unwelcome physical stimuli in a nursing care environment in so far that it created discomfort, and may (as has been identified by this parent) disrupt and disturb sleep:

"at night I don't think the personnel realise how quiet it is and noise travels, so it was a bit noisy at times at night here"

In an attempt to avoid the above-mentioned noise stimulus, and because of a need for increased privacy, parents also requested to have private rooms as the mother below did:

"Sal 'n enkelkamer wou gehad het"
[Translation: I would have liked a single room]

The **general hygiene** of the facilities was also queried by many parents. This may be of concern considering that the parents were in a hospital. Below are excerpts referring to the general hygiene of the unit:

"regular cleaning of the floors especially for gastro patients"

"die kamer is vuil…"
[Translation: The room is dirty…]

"Daar is rooimiere in die saal…"
[Translation: There are red ants in the ward…]

In conclusion, the findings indicate that parents should be supported during the hospitalisation of the child by creating a safe environment in the unit. In creating a safe environment, attention should be given to noise and general hygiene. Parents can be made to feel comfortable and at ease in an environment which is in essence a stressful one. Parents' physical and emotional comfort is very important and needs to be addressed to ensure that they experience the hospitalisation of their child in a positive light. The facilities that are made available to parents should be in good working order and should be a convenience rather than an irritation.

3.4 CONCLUSION

In this chapter the results of the individual interviews and narrative diaries were discussed as parents described their lived experiences of nursing care during their child's admission in a private paediatric unit. Experiences were categorised into two main categories, namely interactive processes that occurred during the child's hospitalisation in a private paediatric unit and the environment within the private paediatric unit.

The aim of the study was to gain increased knowledge and understanding of parents' lived experiences of their child's hospitalisation and to identify situations described by parents as being unsatisfactory and requiring attention from the management of the unit and hospital. The situations requiring attention have now been highlighted. In Chapter 4 additional literature will be presented, followed by the conceptualisation of findings.

CHAPTER 4

Conceptualisation

4.1 INTRODUCTION

In Chapter 3 the lived nursing care experiences of parents during their child's hospitalisation in a private paediatric unit were described. In Chapter 4, a conceptualisation of the nursing care experiences was done. In other words, the findings discussed in Chapter 3 was integrated with existing literature and described in a meaningful way. The aim of this integration is to derive guidelines to manage the nursing care experiences of parents during their child's hospitalisation within a private paediatric unit. The guidelines for managing parents' nursing care experiences of their child's hospitalisation will follow in Chapter 5.

4.2 PURPOSE OF THE STUDY

The purpose of this study was to explore and describe management actions that would assist in the effective implementation of guidelines to effectively support parents during the hospitalisation of their child in a private paediatric unit. This purpose was facilitated during the study by the objectives, set out below.

4.3 OBJECTIVES

The objectives of this study were to:

- explore and describe the nursing care experiences of parents regarding the hospitalisation of their child in a paediatric unit (this objective has already been met in Chapter 3);
- describe managerial guidelines to support the lived experiences of parents in the paediatric unit.

4.4 CONCEPTUALISATION

Parents' experiences were categorised into those relating to the interactive processes within the private paediatric unit, and those related to the environment (namely the private paediatric unit). The former included experiences relating to parents' participation in their child's care, unit management dimensions, as well as communication within the unit. The latter focused on the creation of a safe environment for parents within the private paediatric unit.

Following a discussion of the relevant literature regarding these experiences, the importance of each of the above-mentioned aspects (in a private paediatric unit) was set out, and these will form the basis for Chapter 5, where guidelines are described.

4.4.1 Parents' experiences related to the interactive processes in the paediatric unit

Parents experienced the interactive processes within a private paediatric unit as three different subcategories, namely their willingness to participate in the child's care during hospitalisation, unit management dimensions of planning and organising and communication within the private paediatric unit. These findings will now be presented and integrated with existing literature in a meaningful manner.

TABLE 4.1: Nursing care experiences of parents regarding their child's hospitalisation

MAIN CATEGORY	SUBCATEGORY	THEME	SUBTHEME
Experiences related to the interactive processes in the paediatric unit	Parental participation	• Parents willingness to participate in their child's care	• Empowerment of parents to participate in certain aspects of care
		• Barriers on the extent and intensity of parental participation in their child's care	• Parents' feelings of guilt as a barrier in parental participation in child's care
			• Challenges caused by parents' social roles
	Unit management dimensions: Planning and organising	• Experiences related to family education activities in discharge planning	• Preparedness of parents for discharge
		• Experiences related to aspects of organising the paediatric unit routine	• Provision of quality nursing care
		• Experiences related to organising of resources in the paediatric unit	• Stock availability
			• Cost containment
	Communication in the paediatric unit	• Experiences related to interpersonal relationships	• Parents – nursing care professional relationship
			• A trusting relationship
		• Experiences related to caring in the paediatric unit	• Physical gestures of affection and sensitivity
			• Lack of basic nursing actions
		• Experiences related to information management in the paediatric unit	• Communication flow in the paediatric unit
			• Relevant information
			• Communication style
Experiences related to the environment of the paediatric unit	Creating a therapeutic environment for parents	• Experiences related to facilities available	• Rooming in facilities
			• Nutritional needs of parents
		• Creating a safe environment for parents	• Parental general comfort
			• General hygiene

4.4.2 Parental participation in the paediatric unit

Parental participation in the child's care was pointed out as an important aspect contributing to parents' experiences during the hospitalisation of their child. Parental participation related to parents' willingness to participate in the care of their hospitalised child, barriers to parental participation, such as guilt feelings and power-relations, and challenges caused by parents' social roles, which affect the intensity of parents' participation in the care of their child.

The nursing of a child cannot be done in isolation. It must always be remembered that the child forms part of a family, with parents being the primary providers for the child. Parental participation should be viewed as parents being empowered in the functional aspects of their child's care (such as assisting with everyday care), as well as parents forming an integral and essential part of their child's hospitalisation (Darbyshire in Benner, 1994:188). A key element for fostering parental participation and family-centered care include recognising that the parents and family are constants in the child's life and that the nursing care personnel are simply "visitors" for a brief time. Thus the facilitation of collaboration between parents and nursing care personnel should be addressed at all levels of nursing care, ranging from the care of an individual child to the formation of nursing care policies (Wong, 1995:14).

Various terms that can be used interchangeably to refer to parental participation include shared decision-making, partnership, parent participation and involvement of care.
Parental participation in the child's care during hospitalisation in a private paediatric unit can be facilitated in many ways, as will now be discussed in more detail.

4.4.2.1 Parental willingness to participate in their child's care

The findings have shown that parents are willing to participate in the hospitalised child's care, but need to be **empowered** by nursing care personnel if they are to be active partners in the delivery of **certain aspects of care** in the private paediatric unit. Parents' willingness

to participate in their child's nursing care delivery while in a private paediatric unit should be facilitated and encouraged by nursing care personnel and in particular nursing personnel, through empowerment strategies. A discussion of the literature regarding parents' participation, parents being empowered to take part in certain aspects of their child's nursing care and means to facilitate this, will now follow.

Before discussing parental willingness to participate in certain aspects of their child's care as a cornerstone to empowering parents, a definition of empowerment is needed. Dunst, Trivette and LaPointe (1992:117) provide the following explanation of empowerment: "Empowerment as a partnership (between parent and healthcare personnel) refers to the characteristics of interpersonal transactions that influence and are influenced by the enabling experiences and the effects of these experiences. The use of empowerment as partnership is underscored by a number of important interpersonal characteristics, including open communication, mutual trust and respect, shared responsibility, and cooperation".

A powerful mechanism for **empowering** parents is, firstly, the parent-nursing care personnel relationship. This relationship refers to a *partnership* that implies that parents are capable individuals who become more capable by sharing knowledge, skills and resources in a manner that benefits all participants (Wong, 1995:15). Nursing care personnel have a medical knowledge and background, whilst parents have a comprehensive knowledge about their child, their environment, and family dynamics, and understand the role that the child plays in the family and the family's role in the child's life. Both types of knowledge described above are imperative for treating the child, and should be viewed as equally important (Arango, 1999:124; Strober, 2005:204).

When parents feel like equal partners in a partnership a synergistic relationship is promoted. The Synergy Model can be appropriately used with parental participation in the paediatric unit. Synergy (or working together) describes the outcome of nursing personnel's skills combined with the skills of parents to provide optimal quality care to the child (Pope, 2002:6). A synergistic relationship adds another dimension to the nature of the service being delivered to the child and family in so far that it can complement the work being

done by nursing care personnel and parents (De Lima et al., 2001:560). By making use of the synergistic relationship that can exist between parents and nursing care personnel, the nursing care delivered to the child can be driven by child and family needs, thus making it child specific.

Creating opportunities and means for the parents to display their current abilities and fostering opportunities to acquire new skills and competencies that may be necessary during the care of their child in a private paediatric unit is important in facilitating parental willingness (Wong, 1995:15). It may be that parents are competent with the administering of oral medication to their child, but have never been exposed to inhalation therapy before and this then presents nursing care personnel with the opportunity to enable and empower parents to acquire a new skill that gives them a sense of control over their child's hospitalisation.

A second important aspect of empowering parents to participate in certain aspects of their child's care is the balancing of control between the two parties, thus *power-sharing*. Literature indicates that parental participation is dependent on the control and negotiation strategy a parent adopts. Control of the environment involves negotiation and manipulation of the environment. Parents who feel that the nursing personnel should be in control pose few problems for personnel who feel that they (the nursing personnel) are in control. However, problems occur when parents exert control over their child's hospitalisation, and this is in contrast with nursing personnel's perception of who should be in control. When this occurs negotiation and power-sharing needs to take place in order to get nursing care and associated tasks accomplished (Knafl et al.,1988:97-99). Thus parents will, for example, negotiate with nursing personnel to let their child sleep later and the parents will then administer the medication when their child wakes up.

Participating in a child's care implies that parents must participate and share power in the decision-making processes surrounding their child's hospitalisation. In keeping with the Batho Pele principle of consultation (Muller, 2002:8), the participation and involvement in decisions concerning treatment and care are important principles in nursing, as well as the

core of nursing care policies. In South Africa, this refers to the governments' White Paper for Transforming Public Service Delivery (South Africa: 1997).

Shared decision-making is often interpreted as only involving medical decisions, but it does refer to nursing care as well. Participation by parents in the decision-making process can be viewed as a continuum with various extremes (Sainio, Lauri & Eriksson, 2001:97). Parents should be given the opportunity to be anywhere along that continuum, depending on the strengths and needs of the child, the family and the nursing care professionals who are involved (Wong, 1995:15). It is also a dynamic process and levels of participation may change from day to day or vary between the decisions to be made.

Depending of parents' level of participation in their child's care, they may feel uncomfortable being included in the decision-making process, despite having adequate information, and parents may feel that it is the responsibility of the doctor and nurses to make decisions regarding the care of the child. However, the more involved the parents are with the care of their child, the more they view decision-making as a mutual process in which they are able to share power by making suggestions and discussing options with the doctors and nurses. Parents may concede that the final decision is up to the nursing personnel or doctor, but they feel that they still have the power to veto any decision with which they strongly disagree (Knafl et al., 1988:116,131-133).

It is very important to note that should a decision be taken which may be against parents' expectations, a full explanation for doing so must be given to the parents. Should this explanation not be given or be insufficient, parents could harbour resentment and anger, and this could then jeopardise future interactions between personnel and parents. When parents feel that they are being dictated to by nursing personnel, differences in opinions may emerge and this can cause parents to feel undervalued, angry, confused, hopeless, helpless, powerless and dissatisfied (Lee & Craft-Rosenberg, 2002:5).

During the partnership and power-sharing processes, nursing care personnel should respect parents' choices. Parents should be afforded the opportunity to exercise a choice in the

extent to which they wish to participate in their child's care in a private paediatric unit. Thus, parents must be allowed freedom of choice regarding whether or not to remain with their child during their child's hospitalisation, and whether to be present during procedures or not. The choices parents make should be respected by all nursing care personnel and should not be questioned (Wong, 1995:15). Schoeman (2000:50) also recommends that parents be given a choice whether or not to accompany their child for the procedures, and it should not be a policy that is being forced upon parents.

Literature indicates that young children are immature and dependent on a parental figure and are particularly prone to excessive anxiety related to separation from this parental figure (Kaplan & Sadock, 1998:1229). In South Africa, parents should not be discouraged from staying with their child, especially if nursing personnel are not able to fluently speak the child's language. It is then important that the mother explains to the child what is going to happen and reassures the child throughout the procedure (Schoeman, 2000:50).

In conclusion, nursing care personnel should be guided to augment parents' willingness to participate in their child's care while in a private paediatric unit by **allowing parents to participate in certain aspects of their child's care** and **empowering parents** with new skills as the opportunities to do so present themselves. This can be accomplished through an *equal partnership* and *power-sharing* between nursing care personnel and parents of hospitalised children. Inclusion in decision-making to the degree which parents are comfortable with, should be encouraged and parents should also be given the choice regarding the extent to which they wish to participate in their child's care.

4.4.2.2 Barriers on the extent and intensity of parental participation in their child's care

Whilst the discussion above indicates that parents are willing to participate in their child's care, there are barriers that place limitations on the extent and intensity of parents' participation in their child's care in a private paediatric unit (see table 4.1). These barriers may have been created by parents themselves (i.e. internal factors) or by imposing external factors. These internal factors relates to parents' own feelings of guilt regarding their level

of participation in their child's care, whilst the external factors refer to challenges placed on parents by their social roles.

Factors contributing to parents' feelings of guilt as well the challenges that parents' social roles place on parental participation will now be discussed in more detail.

Parents may **feel guilty** for leaving their child who may be in pain, or perhaps they felt they didn't spend enough time with their child before having to leave again to attend to their social roles. These feelings of guilt could contribute to additional stress for the parents.

Parents' ability to cope with the additional stress of an ill child that has been hospitalised in a private paediatric unit is dependant on the coping skills that they have developed (Kozier et al., 2004:195). *Recognising parental strengths* and individuality and respecting different methods of coping are very important in the facilitation of parental participation (Wong, 1995:14). Knafl et al., (1988:55) note that the manner in which parents manage the hospitalisation of their child often reflects a combination of practical and philosophical factors. Parents strongly believe that they should be with their child during the hospitalisation, and when this is not possible or practical, they enlist the help of outsiders namely siblings and grandparents. It must, however, be noted that parents' belief that they should be with their child as much as possible during the hospitalisation process, is their own belief and is not in any way enforced by current hospital policy. It is, however, enabled by policies. Parents with well established coping skills are able to adapt and plan for future eventualities and often have an extended support network from which they can draw support as it is needed during the child's hospitalisation.

Certain *characteristics* help parents face the crisis situation of having their child admitted to the private paediatric unit better. Various characteristics of adaptable families have been noted, but the following are the most applicable within the private paediatric setting: parents are generally less anxious and are able to differentiate between emotional and intellectual systems. These parents should be able to negotiate much more easily for balance of control as they are able to think rationally about the hospitalisation process and

were to make clear minded decisions, without being too emotionally involved. In a practical setting, parents with these characteristics have been observed as opting to allow the nursing personnel to insert an intravenous cannula for the administration of antibiotics, rather than continuing with oral antibiotics because they are able to rationalise the decision and realise that they should be acting in the best interest of their child (Danielson, Hamel-Bissel, & Winstead-Fry, 1993:132).

Parents who are adaptable and cope well with the stressful situation of having a hospitalised child are flexible and make good decisions. These parents are able to increase and decrease their participation in their child's care according to the child's needs without feeling guilty (Danielson et al., 1993:132).

Adaptive parents can be regarded as fun-loving, with a sense of humour, who enjoy life to the fullest with their child. Despite this, they care deeply for their child and are willing to challenge changes in relationships that occur. Nursing personnel should respect this, and should realise that parents still need to be consulted with, and decision-making should remain a shared process that parents feel a part of (Danielson et al., 1993:132).

However, not all parents share the characteristics of adaptive parents, and even those parents who may appear to be adaptive, with a balance between their emotional and intellectual systems, can potentially function poorly during stressful periods, especially if they have residual anxiety that surfaces during the hospitalisation process (Danielson et al., 1993:132). Even the most balanced parents often feel that they just need the 'one extra pair of hands'.

Parents are strongly influenced by their own sense of responsibility to act as competent parents(defined by their own measures) and the fear of overwhelming guilt should they fail to do so. The care of a sick child is a moral issue and parents feel that they are judged by their actions. They therefore want to do as much as they possibly can within the limitations placed upon them by their social roles, such as work commitments, visiting regulations, etc. (Kai, 1996:17).

The paediatric unit imposes limitations on normal parental roles, and therefore parents depend on interaction with caregivers to provide them with direction (Stratton, 2004:4). The role that parents fulfill within the paediatric unit during their child's hospitalisation needs to be clarified and may be different for each child and parent. It is important to reinforce and strengthen the parental role during a child's illness. Parental esteem support is defined as enhancing, reinforcing and supporting the parental role with the child (Miles, Carlson, & Brunssen, undated:n.p).

It should, however, not only be the parent whose role needs to be clarified but also the nursing personnel whose roles should change from child to child. Titone, Cross, Sileo and Martin (2004:24) stated it perfectly when they concluded: "We look forward to the day when families are no longer considered "visitors" in hospitals. After all, who is the visitor in the child's life? The visitor is certainly not the mother or father. We must remember that nursing care providers are the visitors, the family is constant."

In conclusion, nursing care personnel should be guided to support parents in the extent and intensity to which they take part in the child's care, and in cases where parents experience **feelings of guilt**. This can be accomplished through recognition of *parental strengths* and focusing on *characteristics* of the parent.

Disrupted relationships (with other children and siblings) and parental concern about missing work, are just some of the **challenging social stressors** that parents may face when their child is hospitalised in a private paediatric unit. Parents may feel torn between their own needs, the needs of their other children at home and the needs of the hospitalised child. Parents (especially mothers) feel that the hospitalised child should become the focus of family life, and deserves additional attention and consideration. There are often other factors to consider at home, the most important of these being other siblings. Aspects of their family life, such as parental roles, are not rigid, and this is especially conducive to participating in their child's care (Danielson et al.,1993:132). Outside help is often obtained to assist with the care of siblings, but parents still recognised a need to spend time with

their other children, albeit much less time than normal (Knafl et al.,1988:41-55). Nursing care personnel can also encourage and facilitate *family support and networking* by allowing for open visiting hours and allowing parents to decide who may visit their child, rather than having standard rules for the entire paediatric unit that do not allow for individual preferences (Wong, 1995:15).

The intensity of parents' participation in the care of their child is dependent on many factors, including the clarification of parental and nursing roles, and the openness of the paediatric unit to allow parents to participate more in their child's care. Other factors include home environment factors, as well as the availability of outside help and the ability of parents to delegate tasks to other family members or helpers. By addressing some of the contributing factors (limited visiting hours, restrictions on siblings in the unit) it may be possible to allow for the incorporation of these family members in the hospitalisation processes, thus minimising the disruption of home life for the whole family.

The potential that parents have to function poorly, necessitates that nursing personnel address the parents and view them as holistic people with more than just physical needs. By providing support to parents, parental participation can also be fostered. This can be done by listening to parents and responding to both the verbal and non-verbal messages. Parents who have a support network often receive the additional strength and encouragement, as well as practical assistance that are often required during the hospitalisation process (Kozier et al., 2004:195). Support can also be facilitated by arranging for outside assistance, such as allowing other family members to visit with the child and arranging for clergy visits (if so requested by parents). Support involves an acceptance of cultural, socio-economic and ethnic values, and nursing care personnel must ensure that they are not judgmental of parents. Once again, by allowing siblings to visit the sick child in hospital and having open visiting hours, support can be facilitated.

In conclusion on the **challenges caused by parents social roles**, nursing care professionals should be guided to facilitate family support and networking while the child is hospitalised.

It is important that nursing personnel and nursing care personnel recognise *parents' strengths and their characteristics*, when their child is admitted in the private paediatric unit. By maximising these strengths and abilities, personnel are able to enter into a meaningful partnership with parents where all parties involved stand to benefit, and parents' guilt feelings that act as a barrier to parental participation can be overcome.

Parents' willingness to participate and the barriers on the extent and intensity in the child's care should be addressed. In order to improve and maintain service standards, it is therefore imperative to consider what parents regard as important, and to take into consideration parents' strengths and intrinsic characteristics. To ensure that parental participation is in keeping with the expectations of parents, it is vital that parents be consulted regarding the intensity of care that they would like to give their child, as well as the extent to which they wish to participate in the decision-making process regarding their child's care. It is important to clarify parental and nursing roles, thus ensuring that no misunderstandings occur which will impact on the quality of care received by the child. Family *support* and *networking* should be encouraged, and the role of open visiting hours for parents and patient's siblings should therefore be considered.

The second subcategory regarding parents' experiences of the interactive processes within the private paediatric unit relates to dimensions of unit management.

4.4.3 Experiences related to unit management dimensions: planning and organising

Unit management dimensions were pointed out as another important aspect contributing to parents' experiences during the hospitalisation of their children.

It is necessary to place "unit management" in context. The terms manage and management are heard more regularly than previously. Terms such as manager, general manager and self-management are often heard during everyday conversations, with many "self-help management" books on the bookshelves. The term is no longer limited to the business

industry. Due to its varied use and the broad range of topics related to management, the definitions of management are also varied.

Nursing literature on management has definitions ranging from vague to explicit, as can be seen from the following definitions more applicable to nursing unit management. Swansburg and Swansburg (2002:23) give a definition: "Managing means accomplishing the goals of the group through effective and efficient use of resources". Nursing unit management is defined as the "act of planning, organising, staffing, directing (leading) and controlling (evaluating)" (Marriner-Tomey, 1996:281; Swansburg & Swansburg, 2002:27). Another definition of nursing unit management is the "achievement of the objectives of a specific nursing unit by means of the utilization of the management activities of planning, organising, directing and control, all within the context of the health service's mission, philosophy and policy" (Muller, 2002:104). Within a private paediatric unit the objectives set should include the fostering of an environment that is conducive to parental participation and supportive of parents' experiences during their child's hospitalisation. Parents identified dimensions of unit management that were related to the planning and organising aspects of unit management. While all the components of unit management are interlinked, the literature that follows will only focus on those areas identified by parents.

The role of management increasingly includes all levels of role players (including parents) in the organisation (the private paediatric unit) (Oosthuizen (ed), 2004:21; Muller, 2002:104), and thus there are various levels of management within a hospital setting. In most hospitals management can be divided into two equally important arms, namely nursing services and administrative services. Neither one is more or less important than the other, and whilst they function independently, they are dependent on each other. Both of these services will fall under the direct authority of the hospital manager but this study does not focus on administrative services, and therefore only nursing services will now be discussed.

In many hospitals and nursing care services the nursing service manager heads up the nursing services. This manager is a registered nurse in charge of a nursing service and

responsible for the facilitation of quality nursing care in a cost-effective manner (Mahlo & Muller, 2000:38). As line authority is one of the oldest organisational structures, it is most often used in nursing care settings. The hospital manager or matron delegates authority to the unit manager and this authority is then passed on to nursing personnel, using line or personnel authority. The unit manager is given complete charge of the paediatric unit and at most only needs to consult with the nursing service manager (Marriner-Tomey, 1996:145). The unit manager, together with her/his personnel, are able to set objectives that include making the unit a "parent friendly" one where parental participation is encouraged and parents' experiences are supported. Within the paediatric unit it is the unit manager who is able to facilitate the implementation of the necessary changes highlighted in this study. However, supporting parents' experiences of their child's hospitalisation within a private paediatric unit needs to be the focus of all categories of personnel in the paediatric unit – from the unit secretary, through all the categories of nursing personnel and finally the unit manager as well as the paediatricians and other members of the nursing care team.

The findings on the experiences of parents related to unit management indicated problems with the planning and organising processes in the paediatric unit. Parents narrated their experiences of the discharge 'activities' that relate to the planning process. Nursing care organising activities related to the management of resources, cost containment and unit routine also came to the fore through the experiences of parents.

The core nursing activities that fall under the management processes of planning and organising as defined by Muller (2002:104) and others will now be discussed.

4.4.3.1 Expereinces related to family education activities in discharge planning

An aspect that parents identified as influencing their experiences of their child's hospitalisation in a private paediatric unit was that of **discharge planning**. Parents had concerns regarding discharge planning as it was generally poorly planned and discussed with parents. Planning is the "first management activity and refers to the intentions of the unit manager and group members" (Muller, 2002:105). All other management functions

depend on planning. It is the "process by which managers examine the internal and external environments, ask fundamental questions about the organization's purpose and establish a mission, goals and objectives" (Oosthuizen (ed), 2004:45). Nursing unit managers need to be familiar with the purpose of the institution so that they can state the philosophy, define goals and objectives and prepare budgets to implement their plans, and effectively manage their time and that of the organisation (Marriner-Tomey, 1996:1).

Planning is important as it gives direction to the nursing unit managers and other personnel in the nursing unit to *prepare parents* for discharge. It also allows for personnel to interact effectively in order to have a synergistic effect within the unit (Nieman & Bennet, 2004:104). It is important that personnel are able to contribute to the planning process as this will encourage them to take ownership of goals and objectives (Muller, 2002:104).

Within the private paediatric unit, the nursing personnel need to incorporate the facilitation of parental participation into the unit's philosophy**,** as well as making it part of the goals and objectives of the unit to ensure that they take ownership thereof. It is important that the personnel of the paediatric unit in a private hospital setting meet to discuss the vision, mission and objectives of the unit (within the vision, mission and objectives of the hospital) so that clear objectives can be set. This will allow for the correct planning and implementation of e.g., the discharge of a child. The facilitation of parental participation should be an objective of the whole unit, and steps can then be taken to facilitate this.

Vetter (1995:90) found that many parents expressed concerns about the lack of *discharge planning*. A few children were discharged with parents virtually having no choice in the matter. This highlights the need for better *preparedness of parents* through discharge planning in the paediatric unit. The old adage that "discharge planning starts on admission" should be put into practice more often in the private paediatric unit. If a good initial assessment is done and planned patient management follows, lack of discharge planning can be alleviated (Vetter, 1995:112). As the focus should be on family-centered care it is important that discharge planning is incorporated into the following aspects of family-centered care: parents' inclusion, involvement and partnership with caregivers (Marino

Ganser,1999:http://proquest.umi.com) and parents' participation and collaboration in the care plan (DePompei, Whitford & Beam, 1994:25).

The rapid pace at which technology advances and the impact of managed health care (to be discussed later in this chapter) , mean that children have a shorter hospital stay, therefore spending less time in hospital and more time recuperating at home. Whilst there are many positive results of this decreased hospital stay, there is an often unthought-of negative drawback to the system, namely that, parents now have to shoulder more of the responsibility for either the direct care, or managing the care, of their recuperating child at home (Strober, 2005:203). This implies that health care personnel and, more specifically, nursing personnel have a very important responsibility to educate parents by *providing adequate information* prior to their child's discharge from the hospital. Additional time should be allocated for this task, when the discharge planning is taking place. Nursing personnel may feel that additional discharge teaching increases their workload, and this could be frustrating for them (Strober, 2005:204).

It is important that parents are informed on admission, and during the child's hospitalisation, of possible discharge dates. It is also important to contact other members of the community prior to discharge, if any areas of need have been identified during the assessment or hospitalisation process (e.g. dietician, physiotherapist, etc.) (Vetter, 1995:230). This will again prevent additional delays when parents are already eager to go home.

Delays can also be prevented if discharge planning took logistics into consideration, and this again highlights the importance of communication of information between doctors, nursing personnel and the parents.

In conclusion, nursing personnel should be guided to plan the discharge effectively. Guidance should be provided on preparing parents for discharge and giving them appropriate information before discharge. Once the private paediatric unit has an appropriate philosophy in place that is underwritten by clear aims and objectives that

facilitate parental participation, personnel can set about managing their time correctly and planning for a smooth discharge process that is efficient and effective.

4.4.3.2 Experiences related to aspects of organising the paediatric unit routine

Parents experienced concerns with the organising of *unit routine* and the *provision of quality nursing care* for their child. In order to fully understand the parents' concerns with organising, it is important to define the term organising within the context of this study. Organising refers to the orderly structuring of functions in order to ensure the smooth running of the nursing unit. It is important that there is a line structure as well as allocation of duties, tasks and responsibilities to all personnel within the unit (Muller, 2002:107; Oosthuizen (ed), 2004:63). The structuring of activities is important in the attainment of the set objectives. Organising comprises concepts such as unity of command, chain of command, span of management, division of labour, co-ordination of personnel, responsibility and authority, delegation and flexibility (Nieman & Bennet, 2004:106-107; Oosthuizen (ed), 2004: 64-69).

An example of the morning unit routine in a private paediatric unit could be as follows:

07:00	Handover from night shift to day shift
07:30	Feeding of breakfast to children
08:00	Doctor's rounds commence
08:30	Vital data round
09:30	First tea for nursing personnel
10:00	Second tea for nursing personnel
	Medication round
12:00	Feeding of lunch to children

*** Please note that all intravenous infusions are to be check and recorded hourly ***

The above routine is by no means fixed, as babies may have more demanding feeding schedules, unexpected hygiene needs, and a continuous flow of doctors in and out of the unit. Combined with this are unplanned admissions as well as theatre cases, and discharges.

It is also important to remember that children are totally dependent on nursing personnel for most of their needs depending on the degree of parental participation.

As paediatric patients require more nursing care than recovering adults would, optimally staffing a paediatric unit is one of the most expensive resources in a healthcare environment. Optimal utilisation of the knowledge, skills and experience of nursing personnel will have two-fold benefits: enhancing the quality of care received by parents and their children, and enhancing the work environment of each individual healthcare personnel (Naudé, Meyer & van Niekerk, 2001: 143-145).

An important component of organising within a private paediatric unit is that of delegation of work. The delegation of nursing care could be influential in ensuring that patients receive total care (this includes attending to patients' most basic needs). Attending to a patient's basic need is one of the nurses' "Regulations relating to the Scope of Practice of persons who are registered or enrolled under the Nursing Act" as set out by the South African Nursing Council in Regulation 2598 of 1984 , and should be done by every nursing practitioner regardless of designation (South African Nursing Council, 1985). However, despite all nursing personnel being independent practitioners to a certain degree, it remains the Registered Nurse's responsibility to ensure that the personnel working under her/him perform within their scope of practice.

Case allocation is perhaps one method of ensuring that a patient receives total care, and one person can be held responsible for this. However, it is not always viable in a paediatric unit, as there are too few personnel, and the patients often have their parents with them. Allowing parents to assist in the care of the child is one way of fostering an environment of parental participation and family-centered care. As was elaborated on later, this is very important for parental satisfaction.

A second method that will allow for optimal patient care is the use of functional allocation. Whilst this method allows nursing students and nursing personnel to become proficient in the tasks allocated to them, it decreases the opportunity for parents to building relationships

with various nursing personnel throughout their stay. Functional allocation does, however, allow for the correct "skills mix" of nursing care personnel to be interacting with the parents and child, and this should improve the quality of care given to both parents and their child (Naudé et al., 2001:154).

Regardless of the type of delegation used, it is important that there is an effective **unit routine** that includes time for all needs to be addressed, as well as allowing for individual requirements.

In conclusion regarding unit routine, nursing personnel should be guided to take the parent into consideration in the unit routine. This can be accomplished through the correct approach to the assignment of nursing care. Whilst both case and functional allocation of nursing personnel have their own drawbacks as well as advantages, it is the responsibility of the paediatric nursing unit manager to schedule nursing personnel according to the service needs of the unit. This also implies that the nursing unit manager must be flexible with there approach to the assignment of nursing care, as the needs of the children and their parents changes from day to day (Naudé et al., 2001: 153-154).

4.4.3.3 Experiences related to organising of resources in the paediatric unit

Parents had negative experiences regarding the organising of resources in the paediatric unit. Managed healthcare has been introduced over the past years to ensure that cost-effectiveness is implemented without jeopardising the quality of care given to patients (Muller, 2002:197). This movement was initiated by medical aids and is now an accepted policy in private hospital settings.

Users and funders of nursing care services are beginning to state explicitly the kind and quality of nursing care delivery that they expect from nursing care services. It is not unheard of for patients to complain to their medical aids regarding the quality of care they received at a hospital, or, more specifically, the unit they were admitted in, and as funders of nursing care have contracts with nursing care services regarding the treatment they

expect, it is a breach of contract if services are not delivered as contractually stipulated. This has led to an increase in court cases and refusal to pay for services provided by nursing care services (Booyens (ed), 1998: 599).

Parents experienced frustration when the necessary stock was not available for their children. This led to the hospitalisation experience being tainted and viewed as a negative one in its entirety.

Adequate ***resources management*** and ***cost containment*** are vitally important in a private paediatric unit and all nursing personnel should ensure that they perform their care in the most cost-effective manner possible, while making sure that quality care is not compromised in any way. During the interviews, parents complained about the doctors' costs. While it is not possible to ensure that the doctors overseeing the patient exercise cost containment, it is important that nursing personnel maintain their part in a managed healthcare setting. This can be done by making sure that all necessary stock is obtained as quickly as possible (stock control to ensure **stock availability** should be undertaken together with pharmacy personnel as this department is often in charge of stock delivery to the unit), and that the patients receive the highest level of expected care. Cost containment has financial implications for the unit, and has a direct influence on parents' satisfaction with the care received in the private paediatric unit.

Accountability has become a hallmark in private health care services, with all levels of personnel being held accountable for cost containment and optimal use of stock and equipment. A balance must be found between cost of care, quality of care delivered and patient satisfaction (Ellis & Hartly, 1995:67). Vetter (1995:80-81) suggests that patient satisfaction is important because satisfied patients (in this study the parents) are more likely to cooperate with the people providing them with nursing care, are more likely to fulfill their part of the implied bargain which is met whenever patients (parents) meet nursing care providers, and are less likely to complain to their medical aids.

In conclusion, nursing care personnel should be guided to augment interactive processes in organising the unit. The organising of resources should be promoted by stock availability and cost containment measures to support parents with the hospitalisation of the child.

The final subcategory regarding parents' experiences of the interactive processes within the unit was communication within the private paediatric unit.

4.4.4 Experiences related to communication in the paediatric unit

Communication is at the best of times a very complex interaction and becomes more complex in the paediatric setting, where the child - nursing care provider interaction is very important, but parents must also be included in nursing care interactions. Lack of communication can act as a barrier to empowering parents and building partnerships with them (Strober, 2005:202). Problems may arise when nursing personnel (who are based in a medical environment) must communicate with parents (who are unfamiliar with a medical environment). Thus it was not surprising that parents, who participated in this research study, had mixed experiences when it came to communication in the private paediatric unit. Parents experienced communication within the private paediatric unit relating to interpersonal relationships, caring and information management. These three themes are very closely linked and, at times, it is difficult to separate them from each other.

4.4.4.1 Experiences related to interpersonal relationships

Parents placed significant emphasis on the interpersonal relationships within the private paediatric unit. As mentioned previously, **relationship between parents and nursing care professionals** is a powerful mechanism for enabling and empowering families. It can be facilitated by creating well defined boundaries that separate the nursing care personnel from the child and family. These boundaries are positive and promote the family's control over the child's nursing care. It is also important to maintain open communication by allowing parents to ask questions as needed and by sharing with parents, on a continuous basis and in a supportive manner, complete and unbiased information (Wong, 1995:15,18).

Parents clearly **trusted** the nursing personnel and this enabled them to leave their children in the unit. Parents appeared to be at ease and experienced the unit and personnel as generally trustworthy. The need for trust is a mutual feeling, between nursing personnel and parents. The agreement of trust reinforces the idea that parents need emotional support throughout their child's admission in the private paediatric unit (Shields, Hunter & Hall, 2004:27).

It is important that nurses ensure that they conduct themselves in such a manner that parents feel they can trust the personnel member with their child's life as this is what is essentially on the line. There are many strategies that can be implemented to facilitate a trusting relationship between parents and nursing care personnel. Actions and words must be consistent at all times and nursing personnel must guard against being negatively inclined towards certain patients and/or their parents. Other strategies that can improve the trust relationship between parents and nursing care personnel is being forthright and explaining clearly to parents the medical terminology used, as well as the implications of the child's illness and treatment. By showing parents that they (the nursing care personnel) are trying to understand their concerns and taking a holistic approach towards the child and parents, nursing care personnel will go a long way to fostering the all-important trust relationship (Strober, 2005:204).

In conclusion, nursing care personnel should be guided to promote the interpersonal relationships in a paediatric unit. The relationships that a nursing care professional establish with a patient or parent during a clinical encounter have been described as the heart of medicine. The quality of these relationships influences the flow of knowledge and nurturing that leads to the harmony and understanding which is necessary for successful medical therapeutics (Schoeman, 2000:x). Trust is a very important basis for such relationships and nursing personnel should strive towards achieving a solid base early on in the hospitalisation process.

All parent-nursing care personnel relationships should be based on trust with nursing personnel within the private paediatric unit ensuring that their actions and all forms of communication are consistent and indicative of a caring attitude.

4.4.4.2 Experiences related to caring in the paediatric unit

Nursing is the major caring profession in the world. The primacy of the caring role in nursing is the core of nursing practice (Searle, 2000:92). In other words, caring is the essence of nursing.

Various authors have tried to define and quantify the term "caring". Due to various definitions it is clear that caring is a complex and multi-faceted concept. Leininger (in Kozier et al., 1995:54) observed that caring is the essence of nursing and the most important characteristic of the nurse, while Watson (in Kozier et al., 1995:55) defined nursing as the science of caring. Watson (in Kozier et al., 1995:55) believed that the practice of caring is central to nursing, and that caring in nursing is not just an emotion, but also a personal response that can only be demonstrated interpersonally. Another factor outlines by Watson (in Kozier et al., 1995:55) in her "Philosophy and Science of Caring", was that caring is important in assisting with the gratification of human needs, and is conveyed by recognizing and attending to the all the needs of the patient (including the physical, emotional, social and spiritual). Based on this, nurses who pay attention to the physical and emotional needs of their patients can be described as caring.

Aspects of caring embody the concept of atraumatic care and the development of a therapeutic relationship with the parents and the child. Parents could perceive caring as a sign that the nurse is focused on the "non-technical" aspects of their child (Wong, 1995:17).

As with any science, caring is a process and can be taught. Many training institutions expect nursing students to "pick it up along the way", but this does not always occur. It is important in the nursing profession that caring behaviours are fostered amongst nurses, and that caring behaviours are produced by design rather than by default (Godkin & Godkin,

2004:34). Leininger (in Kozier et al., 1995:54) stated that behaviours such as interest, involvement, helping behaviour, presence, sharing, tenderness, touching and trust are important means of conveying a caring image.

Being personally involved with parents and patients can also indicate to parents that the nursing care professional cares about them and their child (Brown 1988:22). Parents experienced caring towards their child in differing extents. Caring can be shown in the following manner: acknowledging the parents' presence and role in their child's nursing care, listening, making the parent feel comfortable in the hospital environment, involving the parents and the child in all nursing care performed, paying attention to a patient's emotional state rather than ignoring it, and showing *affection and sensitivity* to the parents and child (Wong, 1995:17-18). The parents in this study experienced actions of physical gestures (hands) that could be associated with showing of affection and sensitivity to the parent and child.

Basic nursing actions, such as smiling when greeting a patient, friendliness, informing a parent and child about procedures to be done, responding immediately when the bell call button is pressed, being gentle, and praising and encouraging children are highly valued by parents, and not only facilitate a child's physical recovery, but oversee emotional healing too. Some parents experienced an absence of attendance to basic needs of their child, e.g., bathing and basic actions. This made the hospitalisation experience very negative for them. Caring behaviours can be psychologically sustaining and enabling for the parent and child (Godkin & Godkin, 2004:34).

In conclusion, nursing care personnel should be guided to communicate in such a way that parents experience caring towards their child. This can be accomplished by physical gestures of affection and sensitivity, as well as by performing basic nursing actions such as bathing.

4.4.4.3 Experiences related to information management in the paediatric unit

Information management is important to get the right information to the right people at the right time. There is a large amount of information available in nursing units, but in order for it to improve patient care outcomes and patient satisfaction, it must reach the right people at the right time. Information can be a very powerful nursing resource if managed correctly (McConnell, 2000:37). Parents experienced information management related to the various communication channels used, as well as their inclusion in decision-making based on information received.

There are various communication networks within the private paediatric unit, and these all have their own dynamics which parents experienced differently.

Parents experienced the **lack of communication flow** between doctors and themselves as a negative experience. Parents may find it beneficial and calming if they were orientated during their admission to the private paediatric unit regarding the flow of information and the hierarchy of communication. This would also help to increase parents' sense of control (Strober, 2005:206).

Stratton's (2004:4) study regarding the specific needs of parents in the paediatric unit found that parents universally have the need to be informed regarding their child's health and the care being delivered. Parents may feel that they "needed to know what was going on" and "what they are going to do". When their questions are answered parents feel that their information needs are being met. In addition parents need the information to be conveyed to them in a language that they understand, and therefore medical jargon should be avoided as this only makes parents feel overwhelmed and helpless.

Another pattern of interaction that can be linked to the communication network has to do with the **lack of information** experienced by the parents. By failing to communicate to the child or parents the hierarchy of communication within the private paediatric unit, nursing care personnel and nursing personnel in particular, contribute to parents' frustration and

anger (Strober, 2005:206). Parents who were unable to see or speak to the healthcare practitioner (in this case the doctor) became very angry at the lack of information that they were being given.

Stratton (2004:4) notes that parents regard information on their child's health and procedures to be carried out, as integral to maintaining their own sense of well-being. Parent-clinician (doctor) communication is a fundamental aspect of nursing care. When communication is good, patients are more satisfied with their care. Information given by doctors positively correlates to higher satisfaction (Sobo, 2004:253).

Parents struggle to make sense of their child's illness and this could be worsened when their experience of seeking advice from nursing care personnel add to their feelings of uncertainty and being uninformed. Greater recognition of parents' difficulties and information needs may help to reduce potential disharmony between parents and doctors (Kai, 1996:18). The **communication style** used by nursing care personnel can also inhibit or encourage parents to become more involved in the consultations that take place during the hospitalisation process (Street, Gordon, Ward, Krupat & Kravitz 2005: 969). Information communicated correctly can assist parents in becoming more empowered and competent. However, when there is a communication breakdown in any form, parents experience it very negatively and this then influences their whole experience of their child's hospitalisation in a private paediatric unit.

It is also important to note that by providing parents with adequate information, parents were able to take more control of their child, as they can best explain what is going to take place when nursing personnel perform procedures on the child. This will allow parents to feel more in control and helpful in keeping their child calm during procedures. A parent's encouragement and calm approach is often enough to ensure that a child will also be calm and cooperative (Snyder, 2004:35; Oberholzer 1992: 43).

Wong (1995:1103) proposes the following practical suggestions to ensure that parents are provided with the most important information. These suggestions could be used with every

child's admission and, if done as a standard procedure during admission, may result in less confusion and anxiety caused by too little or unclear information. Nursing care professionals should provide the parents with information regarding the disease that their child has, the treatment and prognosis, the child's emotional and physical reaction to the disease and the probable emotional reaction of the family to the acute crisis of the hospitalisation process. As parents will not be aware of the rules of the paediatric unit, these need to be clearly explained to reduce the feelings of confusion and anxiety. Parents also need to be given guidelines about what is expected of them and what they will need to provide for their child (clothes, toiletries, etc).

Whilst this was not noted in this study, parents may feel that they require more information from their doctor, but lack the confidence to make their real concerns known to the doctor. They are wary of questioning the professional's authority and conscious of pressures on the doctor's time (Kai, 1996: 17).

Sobo (2004:253) also noted that when adequate information is given by the doctor, parents are less anxious and have better outcomes. Parents who received, what they felt was, insufficient information or a poor explanation about their child's condition often became confused and even more anxious, and sometimes even angry. These findings are also substantiated by this study. Parents seek an explanation from nursing care professionals in order to offer them a sense of being in control.

It is possible to assist families to elicit information from their doctor and other nursing care personnel by suggesting that they write down all the questions they want answered during the course of the day or night as the questions arise. This will then help parents to order their thoughts once the doctor has arrived. Encourage them to prepare short, open-ended specific questions regarding their child's condition. This will elicit a more comprehensive reply from the doctor and other nursing care personnel. Encourage the parents to voice their concerns when they don't understand an answer and to have it explained in clearer language. While the doctor or other nursing care personnel are still available, have parents repeat their understanding of what was explained to them to ensure understanding of the

information and terms used, as well as allowing for immediate remedial action if the explanation was not clearly understood by parents (Wong, 1995:1103).

This discussion has highlighted the importance of an effective communication network by using a communication style where communication flows and parents receive adequate information regarding their child. Parents will then respond a lot better to their child's condition and are more co-operative. Nursing care professionals should, therefore be guided to form an effective communication network in the paediatric unit.

4.4.5 Experiences related to the environment of the paediatric unit

As the hospitalisation process is often highly charged with emotions, every effort should be made to make the hospital environment as comfortable and stress-free as possible, with special emphasis on making the paediatric unit less hostile for both the child and parent (Waterson, Helm & Platt, 1997:53). This implies that a safe, therapeutic environment must be created within the hospital, and more specifically, within the patient's room.

4.4.5.1 Creating a therapeutic environment for parents

Parents indicated their concerns regarding the available facilities and safety in the unit environment. Parents' responses during this study indicated that they were not satisfied with the **facilities** available to them during their child's hospitalisation in a private paediatric unit. Thus the facilities that should be made available to parents will now be discussed.

As mentioned earlier, unnecessarily separating parents from their child should be avoided at all costs. If parents so request, they should be allowed to spend unlimited time with their child. Whilst some hospitals may prefer to have separate sleeping facilities for parents, the concept of "**rooming in**" can be implemented anywhere. Providing rooming-in facilities in paediatric wards is becoming the norm (Booyens (ed)1998:116). Problems that were identified during this study are in keeping with potential problems identified by other

authors, namely neglect of the parents' need for sleep, **nutrition** and relaxation (Wong, 1995:1076).

There doesn't appear to be any hard and fast rules regarding facilities that should be provided for the **general comfort** of parents, and it appears that the norm is lazyboy chairs (or equivalent). However, it is possible to lessen the effects of parental neglect by encouraging parents to leave their child for brief periods of time, arranging for separate sleeping facilities away from the child to allow the parents to get sufficient rest, and planning a schedule of alternative visiting with other family members (Wong, 1995:1076).

General discomfort is another reason commonly given for the inability to sleep. This discomfort can be caused by uncomfortable chairs which prevent the parents from sleeping in their usual position. Room temperature or not having enough blankets may also affect sleep (Honkus, 2003:18).

Important aspects to consider when promoting the general comfort of parents are:

- Allow for natural light whenever possible, and use coloured lighting that closely resembles natural lighting in interior spaces (Carr, 2006:2). This may be facilitated by the creation of multi-storey atriums that brings light deep into the building (Anderson, 2003:10)
- Recognise the calming effect that nature has on people, by providing views of the outdoors from the patient's bed or, if this is not possible, photo murals of nature scenes (Carr, 2006:2). Removing ceiling tiles and putting photographic images on the ceilings, will facilitate relaxation in patients who are on strict bedrest, or not able to move towards a window (Anderson, 2003:10). Outdoor spaces that provide opportunities for stimulation in a natural setting are important for the fostering of positive feelings of wellness (Stevens, 1996:25). Gardens offer a unique therapeutic resource. Nature can respond to the isolation and sense of crisis that some patients experience during an illness. The elements (soil, water, light and plants) combine with the rhythm of the seasons to provide sensations that can restore a sense of well-being (Kemp, 1997:48).

- Pay attention to the signage used throughout the hospital and within the unit, as this will assist parents to find their way around the unit. It will lessen their confusion and facilitate movement between units and treatment areas (Carr, 2006:2). Signage can also increase parents' awareness of their environment and facilitate orientation (Stevens, 1996:26).
- In a paediatric unit there should be appropriate designs and furnishings to cater for the relevant age groups. This could include lively art works, small chairs and tables for younger children and carpets on the floor. A pleasant outdoor play area not only provides an area for relaxation but also the opportunity for children to interact with other children (Waterson et al., 1997:94).

Not only is the creation of a therapeutic environment important for healing and patient care, it is important for enhancing the hospital's public image and is an important marketing tool. With the emergence of managed care, hospitals are now vying for limited funds. Hospitals have to compete with other institutions and service providers for patients. When patients experience the hospital positively, they come back and recommend the hospital to others. World class organisations realise the importance of being close to its customers, and have a deep understanding of how its clinical and business support processes impact on customer perceptions (Roth, 1993:3). Thus the creation of a therapeutic environment can, in fact, affect the bottom line of the hospital. The users of hospitals are also pushing the drive to "humanise" hospitals based on their high expectations. This has been noted by hospital management and is being encouraged and implemented by hospital management (Anderson, 2003:10).

In conclusion, nursing care personnel should be guided to create a safe environment for parents by ensuring adequate facilities for parents. This can be accomplished by adequate rooming-in facilities, fulfilling the nutritional needs of parents and attending to the general comfort of parents.

4.4.5.2 Creating a safe environment for parents

Even if parents are not rooming in with their child, it is important that a *safe environment* is created for when the parents are with their children. This implies addressing the parent as a holistic person with physical, psychological and social needs. Thus the aspects of a safe environment will now be addressed with reference to stressors in a paediatric unit.

There are many stressors that have been identified within a paediatric unit. These include environmental, physiological and social stressors. Parents indicated noise and general hygiene as problem areas in the unit environment. These are mainly related to environmental stressors.

Environmental stressors are by far the largest group of stressors found in the paediatric unit. Equipment **noise** (including the ringing of phones, alarms set on monitors, suctioning of patients and computer printouts) add to the noise pollution that is often found in any paediatric unit. Patients located closest to the nurses' station and storage rooms are often subjected to the most noise and light (Honkus, 2003:17). Nursing personnel often place the smallest or most critical children nearest the to nurses' station, yet these are the children that require the most sleep. Human sounds such as talking, laughing, other children crying and coughing can also affect rest and sleep (Wong, 1995:1121).

Parents spending the night with their child can also experience interrupted sleep due to the many nursing procedures that are carried out during the night. While the child might not wake up during such procedures, the parents, who are possibly not sleeping as soundly, may be disturbed every time. Sleeplessness can also induce additional stress, and this is perhaps one of the major problems in the paediatric unit: parents who are rooming-in, spend a sleepless or sleep-disturbed night next to their child's bed and are then irritable the following day, making them more critical towards nursing personnel in the paediatric unit (Wong, 1995:1076).

In addition to sensory overload from noise, lighting has also been identified as a factor preventing sleep. Bright lights from the nurses' station, lights that are not dimmed and lights that are turned on at night are all very disrupting to a patient's sleep (Honkus, 2003:17). Overhead lights should be dimmed and televisions switched off early in the evening to allow for the child to get a decent night's rest. Curtains should be lined to ensure that light from outside (street lights, garden lights, etc.) does not disturb the child. Constant light also disturbs diurnal rhythms (Wong, 1995:1121).

Traditionally, nursing personnel have thought of safety in relation to the patient's immediate environment, and this awareness is no less important today in spite of the broader focus on human protection. The Constitution of South Africa (No 108 of 1996) states that every person has the right to respect and the protection of human dignity: beneficence and prevention of or protection against harm. Thus it is every patient's right, regardless of the hospital setting that they find themselves in, to have a safe and comfortable environment.

Factors affecting the **general hygiene** of the unit were identified by parents as being less than satisfactory, with dirty floors and ants being highlighted by parents in their narrative diaries. This should be unacceptable in any environment, but especially in a hospital environment and more specifically a paediatric unit, where children, who are curious by nature, often whilst crawling, will pick up objects from the floors and investigate them. This could further contribute to parents' stress as they could now be concerned about what their child is picking up from the floor.

Parents didn't mention psychological safety that could include lack of privacy which is compounded by parents inability to communicate openly with each other and personnel regarding their child's condition for fear of being overheard, and (as mentioned previously) inadequate knowledge or understanding of the situation (Wong, 1995:1121).

All of the above-mentioned stressors must therefore be considered and addressed in the creation of a safe therapeutic environment. Important aspects to be considered when creating a safe therapeutic environment include the following:

- Use varied colours and textures carefully. Colours that are inappropriate can interfere with patient assessment as they may influence skin pallor and tone, and disorientate or stimulate children and their parents (Carr, 2006:2)
- Control the quantity and quality of stimulation as this will enhance a safe environment and minimise harmful stimulation (Stevens, 1996:25). Excessive stimuli of noise and bright lights can increase stress levels and has a patho-physiological effect on patients. This needs to be addressed if a "humanised" caring environment is to be created (Fontaine, Briggs, & Pope-Smith, B, 2001:21-23).

It is concluded that a therapeutic environment should be safe for parents. Nursing care professionals should be guided to attend to noise and general hygiene in the unit. From the discussions on the environment, it is clear that the aim of a therapeutic environment should be to create a safe, well-equipped environment, both physically and perceptually. This can be facilitated in the private paediatric unit by controlling the quantity and quality of stimulation, enhancing therapeutic and minimising harmful stimulation; enhancing social interactions and allowing parents a space where they can comfortably interact with other parents or family members, allowing for privacy and providing more opportunities for personal control, based on their own individual choice (Stevens, 1996:25).

From the above-mentioned, the creation of a therapeutic environment includes the creation of a warm, caring, aesthetically pleasing physical environment. There should be enough room to allow for both parents and child, without hampering nursing care and with the emphasis on maintaining comfort. An outdoor play area will allow for room to play, as well as providing for the sense of calm that comes from nature. This will also allow for parents who are staying with their children to feel less infringed upon during their stay.

4.5 CONCLUSION

From the above discussions of the literature, there is not a mass of information regarding aspects related to parents' lived experiences of their child's hospitalisation in a private paediatric unit. The challenge, however, lies in implementing guidelines for nursing care personnel to facilitate parents' positive experiences. These guidelines will be described in Chapter 5.

Chapter 5

Guidelines, limitations and recommendations

5.1 INTRODUCTION

The purpose of this study was to describe managerial guidelines that could be implemented to effectively support parents during the hospitalisation of their child in a paediatric unit. The guidelines derived from the integration of the findings of this study and existing literature and serve to fulfill the purpose of this study. From the findings of this study, it is clear that there are many aspects that need to be addressed in order to allow for the effective support of these parents.

A brief overview of the objectives, research methodology used, findings of the study, and guidelines for the implementation of managerial actions was provided. The possible limitations of the study as well as recommendation for nursing practice, education and research will also be set out.

5.2 RESEARCH OBJECTIVES

The objectives of this study were to:

- explore and describe the nursing care experiences of parents regarding the hospitalisation of their child in a paediatric unit;
- describe managerial guidelines to support parents with their lived experiences of their child's hospitalisation in a private paediatric unit.

5.3 RESEARCH DESIGN AND METHODOLOGY

A qualitative study was conducted whereby the lived nursing care experiences of parents were explored and described within a context using interpretive-phenomenological methods. Parents were invited to take part in an unstructured individual interview to ascertain their lived experiences of their child's hospitalisation in a private paediatric unit. The interviews were then transcribed verbatim, and the content underwent analysis, making use of Tesch's method of coding. A coder and co-coder did this independently and results were finalised during consensus discussions. Guba and Lincoln's methods of ensuring trustworthiness were applied, namely strategies of credibility, transferability, dependability and confirmability.

The findings of the study are presented in a table format on the following page (Table 5.1).

The meaningful integration of the findings into current literature was done during the conceptualisation phase (Chapter 4). The aim of this integration was to derive guidelines to support parents during their child's hospitalisation in a private paediatric unit. The guidelines derived from the integration of the findings of this study and existing literature will serve to fulfill the purpose of this study.

TABLE 5.1: Nursing care experiences of parents regarding their child's hospitalisation

MAIN CATEGORY	SUBCATEGORY	THEME	SUBTHEME
Experiences related to the interactive processes in the paediatric unit	Parental participation	• Parents willingness to participate in their child's care	• Empowerment of parents to participate in certain aspects of care
		• Barriers on the extent and intensity of parental participation in their child's care	• Parents' feelings of guilt as a barrier in parental participation in child's care
			• Challenges caused by parents' social roles
	Unit management dimensions: Planning and organising	• Experiences related to family education activities in discharge planning	• Preparedness of parents for discharge
		• Experiences related to aspects of organising the paediatric unit routine	• Provision of quality nursing care
		• Experiences related to organising of resources in the paediatric unit	• Stock availability
			• Cost containment
	Communication in the paediatric unit	• Experiences related to interpersonal relationships	• Parents – nursing care professional relationship
			• A trusting relationship
		• Experiences related to caring in the paediatric unit	• Physical gestures of affection and sensitivity
			• Lack of basic nursing actions
		• Experiences related to information management in the paediatric unit	• Communication flow in the paediatric unit
			• Relevant information
			• Communication style
Experiences related to the environment of the paediatric unit	Creating a therapeutic environment for parents	• Experiences related to facilities available	• Rooming in facilities
			• Nutritional needs of parents
		• Creating a safe environment for parents	• Parental general comfort
			• General hygiene

5.4 GUIDELINES TO SUPPORT PARENTS DURING THEIR CHILD'S HOSPITALISATION IN A PRIVATE PAEDIATRIC UNIT

Guidelines can be implemented to effectively support parents during their child's hospitalisation in a private paediatric unit. Possible managerial actions that could be taken are by no means limited to the selection below.

5.4.1 Guidelines related to the interactive processes in the private paediatric unit

Based on the narratives of parents during this study, the following guidelines were developed to address the themes raised by parents. This will ensure that parents whose children are admitted to the private paediatric unit in future will be supported in an appropriate manner with regard to their participation in their child's care. Unit management dimensions will address incorporating parents into the unit routine as well as managing resources in a cost containing manner. The guidelines should also ensure that effective communication takes place in the unit between all parents and nursing care personnel.

Guideline 1: The unit manager in charge of the private paediatric unit should encourage parental participation in the unit

The South African Patient's Right Charter (1999) states that the patient (in this study the parent is inherently also entitled to all patient's rights) has the right to participate actively on any decisions regarding their healthcare. Whilst the Department of Health has made this decision at National level and is implementing it through the Patient's Right Charter, it is important that it filter down to the lower levels of healthcare as it ultimately affects the user of the healthcare services.

The unit manager of the private paediatric unit should focus her nursing personnel on empowering parents to participate in certain aspects of their child's care to the extent and

intensity that they feel comfortable with, recognising parent's strengths and intrinsic characteristics and minimising feelings of parental guilt created by social roles.

The following are managerial actions that could be implemented by the unit manager through means of an appropriate strategy:

- In decision-making, parents should be consulted regarding the level of care that they would like to give their child. It is also important for nursing care personnel to consult with parents on a daily basis as the child's condition improves or deteriorates. This consultation could be facilitated by the most senior nursing personnel on the shift, or allocated to work with the parent and their child, to meet at least daily with parents. This meeting could take place at set times (for example, following the doctor's rounds or at a specified family meeting) or it could be an impromptu, informal meeting that takes place.
- Solicitation of parents input into their child's nursing care delivery needs to be an ongoing and dynamic process, and not just a "once-off". This is because circumstances, priorities and needs may change over the duration of the child's hospitalisation (Pogoloff, 2004:118). Parents should be asked at least daily, if they would like to take part, or assist the personnel in any way. When the nursing care personnel allocated to care for the child go and introduce themselves to the parents, they could enquire if there are any particular tasks that the parents assist with or would like to assist with. By enquiring and asking the parents themselves, the nursing care given can be continued and parents also have an opportunity to increase their input into the child's care.
- Parents should also be taken into consideration in the decision-making process regarding their child's care. Where parents are not present during the doctor's rounds, nursing care personnel could phone the parents and inform them of changes in treatment and improvement in the child's condition. This is a practical way of getting parent's "buy-in" into the care being given to the child, as well as emphasizing parent's importance in the treatment of the hospitalised child. Should the decisions taken by parents not be implemented, it is the responsibility of the

'responsible person', be it the doctor or the nursing care personnel who vetoed the decision to phone the parents and explain the reasons for their actions as soon as possible.

- In the routine management of the unit, the role of open visiting hours for parents and patient's siblings should also be considered. Open visiting hours could place less stress on parents to balance their inherent need to be with their hospitalised child and their need to spend time with other children at home. Open visiting hours could also allow for parents to be supported from external social networks during the trying time of their child's hospitalisation. Open visiting hours will need to be discussed with hospital management and in some private hospital groups, group management. The nursing unit manager could suggest open visiting hours be trialed at their hospital and a parent satisfaction survey conducted before provincial or national roll out of open visiting hours.

It is important that the unit manager of the private paediatric ward realizes that there are certain barriers on the extent and intensity of parental participation in child's care. The unit manager should guide the nursing personnel in overcoming these barriers so that patient care is not jeopardized in any way. This could be facilitated through the following:

- Parents who choose to not be actively involved in their child's care should not be victimised or made to feel inferior, and their decision should be respected at all times. Parents should not be made to feel as though their motives are being questioned, and all nursing care personnel should be guided in not being judgmental. This implies that nursing personnel must be cautioned regarding their body language, tone of voice and non verbal communication patterns, that could lead to parent's feeling victimised.
- It is important to clarify parental and nursing roles, thus ensuring that no misunderstandings occur which will impact the quality of care received by the child. This could also be done at a scheduled family meeting early in the child's admission or impromptu throughout the child's hospitalisation.

Guideline 2: The unit manager should have the ability and expertise to be able to manage the private paediatric unit through detailed planning and organising of nursing care activities in the unit

The Batho Pele principles as set out in the White Paper on Transforming Public Service Delivery (South Africa: 1997) promotes the rights of the patient (parent) with regard to what service standards can be expected from the nursing units. Thus standards set should be of the highest, and this requires that the unit manager has Quality Improvement Programmes in place to facilitate the setting and maintaining of such standards (Muller 2002:9).

The unit manager should guide nursing personnel to plan the discharge process effectively, to include parents in the unit routine and to manage resources whilst promoting cost containment.

Experiences related to family education activities in discharge planning can have an adverse effect on parent's perceptions of their stay in the private paediatric unit. It is therefore very important that the unit manager, together with the multidisciplinary team compile action plans and strategies that directly address the discharge process. Managerial actions that could be included in such a strategy include:

- Parents should be informed at admission and during the child's hospitalisation of possible discharge dates. Once again, this emphasizes the usefulness of a family meeting that could be held with members of the multi disciplinary team, who would be treating the child. Doctors, nursing care personnel and physiotherapists are examples of team members who could attend such meetings, and provide relevant information to parents.
- Other members of the community should be contacted prior to discharge, if any areas of need have been identified during the assessment or hospitalisation process (e.g. dietician, physiotherapist, etc.). By contacting team members prior to

discharge, the discharge process does not have to be delayed by parents waiting for other healthcare professionals to consult with them.

- Effective communication between doctors, nursing personnel and the parents should be ensured. This could be facilitated by the nursing care personnel phoning parents on at least a daily basis to inform them of developments in their child's condition and treatment.
- Where possible, nursing personnel should consider logistics, such as transport and parents who may have to be at work during the planned discharge time, while doing their discharge planning. Discharge planning could be discussed at the family meetings that are held during the child's admission to the paediatric unit. This would allow parents to partake in the discharge planning and any time constraints or requests that they may have, can be raised and taken into consideration.

A unit routine needs to be flexible enough to accommodate the varied needs of the parents and children in the paediatric unit. Thus the unit manager needs to coordinate all therapeutic services, the provision of a safe environment, the physical care of the child in respect of their hygiene, feeding requirements, and even recreation (Mellish; Brink & Paton 2001:4). This implies an enormous amount of planning and consultation together with parents in accordance with the Batho Pele principle of consultation (Muller, 2002:9). The process of consultation can be promoted by the following:

- All personnel of the private paediatric unit should participate in the setting of a unit specific vision and mission, as well as appropriate goals for the unit. The paediatric unit manager could use open, two-way communication whilst compiling the vision and mission for the unit. The individual nursing personnel's, and nursing unit's aspirations, expectations, intentions and opinions must be considered. The unit manager should encourage nursing personnel to rise above personal interests and work as a team during the setting of the vision and mission (Naudé et al., 2001:138)
- A hard copy of the vision and mission could be handed out to all nursing personnel, and should be communicated clearly and consistently. This can be achieved by explaining the vision and mission in such a way that it becomes practical and

understandable for all categories of nursing personnel in the paediatric unit (Naudé et al., 2001:138). The vision and mission could also be displayed in the unit so that parent's can also be made aware of the intentions and aspiration of the unit in which their child has been admitted.

- The type of delegation used should be dependent on the needs of the patient and should be dynamic so as to facilitate the needs of patients and parents in the unit. When functional allocation is used, the unit manager should rotate the personnel so that personnel do not become bored with tasks allocated to them. Boredom could lead to nursing personnel becoming complacent, and the quality of the nursing care received may be adversely affected.
- In order to increase the nursing care personnel's attention to their daily tasks and responsibilities, it may be useful for personnel to sign a delegation book on a daily basis, whereby they accept responsibility for the correct execution of the tasks delegated to them (Naudé et al.,2001:154).

All resources and services impacting on the private paediatric unit should be optimally organised to promote patient satisfaction. The unit manger could implement the following managerial actions to promote organised resources:

- Service contracts should be drawn up between the private paediatric unit and the pharmacy, as well as other departments that are in interaction with the unit (pharmacy, technical department, kitchen, housekeeping services, etc.) to ensure that the patients receive timely treatment and quality care.
- Nursing care should be evaluated continuously to ensure quality patient care at all times. This can be accomplished by instituting a risk management team or clinical governance team, who would be responsible for the auditing of nursing care, as well as the investigation of any "failure of care" incidents, which could have any form of negative repercussion for the healthcare service. It could also be very useful for all nursing care personnel to audit nursing documents on a monthly basis in order to identify possible "failure of care" areas. This will draw nursing care personnel's attention to their own shortcomings in the delivery of quality patient care.

Guideline 3: The manager in charge of the private paediatric unit should promote meaningful communication between all role players in the unit

Nursing in South Africa is largely governed by the South African Nursing Council (SANC). In accordance with the Nursing Act No 45 (South Africa; 1944), the SANC have set out regulations that must be followed or there could be disciplinary repercussions. Professional confidentiality is an important aspect of professional conduct and is supported by the Patient's right Charter as well (Department of Health 1993:3).

The unit manager of the private paediatric ward should promote interpersonal relationships in the paediatric unit, with special emphasis on fostering a trusting, caring parent-nursing care professional relationship that promotes the communication of information by using a communication network that ensures parents receive adequate information.

Interpersonal relationships should form part of continuous personnel development. This could be facilitated through the following actions:

- Nursing personnel should respect and guard confidentiality at all times. They should not discuss any other child or use other children as comparisons, even favourable ones. If parents hear nursing care personnel discussing other children with anyone other than his/hers parents, it may open the door for distrust (Pogoloff, 2004:116)
- Each conversation with parents should start with a positive statement about their child. When nursing care personnel provide parents with positive feedback, parents will look forward to speaking with them (Pogoloff, 2004:116).
- Nursing personnel should allow parents to be part of the decision-making process regarding their child's care, and they should respect informed decisions that have been made.

Caring actions should be an inherent part of nursing; however, when they are lacking it is possible to encourage and motivate nursing personnel through the following:

- Nursing personnel should be friendly at all times and basic actions such as smiling when greeting a patient should be encouraged. If necessary nursing care personnel should receiving coaching regarding their demeanor when dealing with parents and patients.
- Nursing personnel should be gentle and praising, and encourage children, which will allow parents to feel at ease and which will facilitate a trusting relationship between parents and personnel, as well as children and personnel.
- Nursing personnel should pay attention to parents' emotional state rather than ignoring it. Nursing care personnel should be sensitive to the emotions of parents. Topics or comments that may seem insignificant to nursing personnel may sound harsh or negative to parents (Pogoloff, 2004:117). An area should be allocated within the unit where parents and nursing personnel can discuss sensitive matters. It is also important that parents are reassured that while they are in another part of the unit or hospital, that their child is being taken care of by the nursing personnel in the unit.
- Nursing personnel should be available during their working times to respond immediately to parents' queries. This could facilitate parent's trust in the personnel as well as build open communication networks. The nursing unit manager should ensure that the number of nursing personnel that she has scheduled to be on duty will be able provide safe and adequate care to both child and parent (Swansburg & Swansburg, 2002:101). The nursing unit manager should ensure that tea times are scheduled in such a way that the ward will still be covered with sufficient nursing personnel during tea and lunch times.

Facilitating effective communication networks is an integral part of the nursing unit manager's responsibility. Not only is courteous towards the parent, but it is also important that parents are provided with appropriate information regarding the services available to themselves as well as their child's treatment (South Africa; 1997:9)

- The child and his/her parents should be informed about procedures to be done prior to it being done. According to the Health Act, 2004, of South Africa, doctors are responsible for explaining the procedure to be performed. It is no longer the responsibility of the nursing care personnel.
- Nursing personnel should respond immediately when the bell call/ button is pressed. By implementing hourly unit rounds, nursing personnel would be able to anticipate potential problems as well as decrease noise in the unit (Hunter, 2006:4)
- Personnel should be encouraged to communicate honestly with parents and provide them with sufficient information to make informed decisions.
- Communication break-downs should be avoided and it may be necessary to consult with all departments interacting with the paediatric unit (technical, kitchen, pharmacy, theatre, etc.) regarding acceptable communication channels to be used with the unit.
- Information should be obtained from parents using various forms. Provide parents with an opportunity to communicate about their child in writing, by phone, and with face-to-face interactions. Parents may prefer to use one or more forms of information. It may also be more convenient for parents to take a phone call, rather than having to read pages of information.
- Nursing care personnel should be encouraged to communicate using the parents' preferred mode of communication, rather than always using nursing care personnel's most convenient form of communication. This could be noted during the admission assessment, or parents could be asked to complete a short questionnaire regarding their communication preferences.
- Various forms of communication should be provided throughout the unit, such as verbal communication, pamphlets on admission, posters on the walls and access to additional information (e.g. paediatric textbooks and other relevant reading material).
- The use of a computer-based information center should also be considered. This would make information easily accessible at all times, and not only when it suits nursing care personnel. Parents may find it more convenient to "surf the web" for

information while their child is sleeping, rather than when their child is awake and demanding attention.

5.4.2 Guidelines related to the environment of the private paediatric unit

Based on the interviews and narratives of parents as well as the observations of the researcher, the following guidelines were developed to address the themes raised by parents. This will ensure that parents whose children are admitted to the private paediatric unit in future will experience a therapeutic environment for themselves which has sufficient facilities, is safe and comfortable for parents who choose to participate in their child's care.

Guideline 4: Unit managers should motivate and budget for facilities that could contribute to creating a therapeutic environment for parents within the private paediatric unit

The creation of a therapeutic environment includes the creation of a warm, caring, aesthetically pleasing physical environment. Unit managers are responsible for the establishment and maintenance of a therapeutic environment that will facilitate a parent's physical, mental and spiritual health. The creation of the above described environment is seen as a basic patient (parent) right as set out in the Patient's Right Charter (Department of Health; 1993:3).

The unit manager of the private paediatric unit should facilitate the creation of a safe, therapeutic environment for parents, where parents can be comfortable with adequate facilities and minimal external stimuli.

Practical means for creating should an environment could include:

- Allowance should be made for privacy for child and parents. This will provide parents for an area that they can retreat to, where they can spend quiet time with their child as well as possibly maintaining, where parents can, their own routine, to a certain degree.

- A protected and safe outdoor play area should be provided. This will allow for the children to play and socialise with other children, as well as providing parents with an opportunity to socialise with other adults and "break free" from the four walls that they may find themselves enclosed by.
- The quantity and quality of stimulation should be controlled, by enhancing therapeutic stimulation and minimising harmful stimulation. This can be facilitated through the use of "Silence" boards displayed prominently, the playing of calming background music or nature sounds, as well as the use of curtains and, where appropriate, carpets, to act as a buffer for the noise.
- Social interactions should be enhanced and parents allowed a space where they can comfortably interact with other parents or family members. This could be a visitor's lounge or a dedicated parent's room where comfortable chairs and refreshment facilities are provided for parents use.

5.5 POSSIBLE LIMITATIONS OF THE STUDY

Only seven parents took part in the study, which may be too small a group to obtain accurate information. Parents who declined to take part in the study cited anxiety and concern for their child as their overriding reasons.

Despite parents fulfilling the selection requirements, they were at times unable to "grasp" the intended meaning of the term 'experience' and were thus unable to give dense descriptions of their lived experience during their child's hospitalisation in a private paediatric unit.

The study was conducted in a private paediatric unit, therefore generalisation outside of this environment may be difficult to justify.

5.6 RECOMMENDATIONS

Recommendations for nursing practice, education and research will now be set out.

5.6.1 Recommendations for nursing practice

Parental participation should be encouraged in all paediatric nursing units with units becoming more "parent friendly". This can be done by implementing the guidelines set out in Chapter 5 of this study.

Policies to promote parental participation should be written by the unit manager and nursing personnel must be made aware of the policies, and where they can be located for easy reference. The policies can then be revised as more information becomes available with regards to effectively supporting parents during the hospitalisation of their child in a paediatric unit.

To ensure optimal implementation of the policies and guidelines, in-service training should be given to all member of the multi-disciplinary team, who partake in the hospitalised child's care. This will ensure that there is continuity of care for child and parents.

5.6.2 Recommendations for nursing education

Parents need to receive accurate information regarding their participation in their child's care during hospitalisation. This information should preferably be presented in various forms at appropriate intervals.

Nursing personnel should receive in-service training (both formal and on-the-spot) regarding the importance of parental participation, as well as the benefits thereof for the parents and the nursing personnel.

5.6.3 Recommendations for nursing research

Research on parental participation in their child's nursing care is very limited in South Africa and the following could be future research topics:

- Factors influencing parents' participation in their child's care;
- Nursing personnel's attitude towards parental participation;
- The extent to which parent's can be effectively coached to continue with home care in terminally ill children
- Comparison between parental participation in a Paediatric Intensive Care Unit setting and a paediatric unit, as well as comparative studies between parental participation in acutely ill children and terminally ill children.

5.7 CONCLUSION

This study has shown that there is a demand for parental participation at various levels during the hospitalisation of a paediatric patient. Whilst some parents experience it positively, other parents appear to be resistant towards it. Regardless of this, parents' participation in the care of their hospitalised child is becoming an increasingly popular phenomenon and further research needs to be conducted around this wide field of study of which we, in South Africa, have limited knowledge.

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ANNEXURE 1: ETHICAL APPROVAL FOR STUDY

ANNEXURE 2: LETTER OF CONSENT

Letter of Consent

To all interested parties,

I, Michelle Verwey, am currently a M Cur student at University of Johannesburg. I am presently busy with my Masters degree in nursing administration.

I am hereby inviting you to take part in a research project focusing on the lived experience of parents during the hospitalization of their child.

You will benefit by being given the opportunity to express your opinions and to receive feedback regarding the findings of the study. It is also possible that your input may result in positive changes being made to the nursing care within the paediatric unit. As far as I can tell, there was no risks or discomfort to yourself or your child

I would require more or less an hour of your time, during which to conduct an individual interview, and with your permission, this interview was recorded on audiotape and then transcribed, this tape will then be destroyed. Your name will not be used on the transcription, so that data cannot be linked with your name. Your confidentiality and privacy was respected and maintained at all times.

Should you not wish to partake in an interview you was requested to compete a narrative diary in which your record your experiences either on a daily or random basis. Again these diaries will not be identified and you can return them when your child is discharged. They was destroyed once the data analysis is competed.
Should you wish to partake in both aspects of the research kindly mark the appropriate block on the reply slip.

Your participation in this study is entirely voluntary: you have the right to refuse and withdraw from the study at any time, without fear of prejudice and discrimination.

There was no financial implications for yourself, and I will avail myself to meet at a time suitable for yourself. The narrative diary was provided on admission.

If you have further enquiries or comments regarding this research project, please do not hesitate to contact me on the following number: 083 459 6884.

Thanking you in anticipation,

Miss M Verwey

M Cur Researcher

✂✂ _____

REPLY SLIP

I, ……., hereby give my written consent to take part in the research project titled: a management strategy to support parents with the hospitalisation of their child in a private paediatric unit. The ethical standards and implications have been explained to myself and I understand the content of this letter.

I wish to take part in:

☐ the narrative diary

☐ the individual interview

☐ both the narrative diary and individual interview

_____ _____

Signature of participant Date

ANNEXURE 3: EXTRACT OF INTERVIEW TRANSCRIPTION

Interviewer: This research is directed by one question, namely, how did you experience your child's hospitalisation in the paediatric ward?

Respondent: It was fine. Although it was his first time being admitted, my daughter has been here before. The worst was when they told me I wasn't allowed to go with her when they put the drip in. said I should go have a Cup of coffee. That was really silly, I thought. What mother can leave her child while they hold her down and hurt her. There were three of them inside and she is only four years old. What where they doing? But other than that everything was fine.

How did the ward routine influence you, things like, bathing and changing of sheets and handing out medicine, etc?

That was fine. That's why she is here. There were other mothers, who said they must leave the children because they were sleeping, but I felt it was fine because that's why she is here, to get better, and the personnel work so nicely with her, that even f she is sleeping, she just sleeps right through every thing. They are very gentle with her, and talk to her and distract her the whole time. Her bed was changed alot, more than at home actually, when it just looked dirty the linen was changed. Everything and every one is very neat here.

Was there anything else that you experienced negatively?

At night I don't think the personnel realize how quiet it is and noise travels, so it was a bit noisy at times at night here, but that was the only problem. Everyone was really great, the personnel \are very nice. They build good relationships with the child and you don't feel bad to leave them alone here when I go to do my shopping and things like that, you need to get out of here too, you can't just sit in these 4 walls, it gets a bit much. You can only watch so much TV, and life goes on out there.

Do you stay with her at night as well?

I stay until about 12 o'clock and then I go home, but I am back by 5 again, so I don't think she knows I am gone.

Is there any other aspect that concerned you while you were here?

Not at all. I watched her getting better all the time, and that makes it all worthwhile for me. That's what counts, isn't it. That's why we are here, to get better.